MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Thursday, April 9, 1998

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.

The meeting in the above-entitled matter convened, pursuant to notice at 10:14 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
P. WILLIAM CURRERI, M.D.
ANNE JACKSON
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH LAVE, Ph.D.
DONALD THEODORE LEWERS, M.D.
HUGH W. LONG, Ph.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, M.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA

P R O C E E D I N G S

DR. WILENSKY: Good morning. We're a few minutes late, as is our tradition. Welcome to the first post-March report meeting of MedPAC. We are going to be using the two April meetings to get ready for our June 1st report, and the first session is on variation in payment across settings looking at ambulatory care, and Jim, why don't you start?

DR. MATHEWS: Thank you. Good morning. I can't tell you how ecstatic I am to be here right now at this moment in time. I guess it will teach me to sleep through staff meetings. I kept hearing phrases, something to the effect of needing to offer up an appropriate sacrifice, and give the commissioners some fresh meat to chew on, and here I am.

[Laughter.]

DR. MATHEWS: Also contrary to what your agenda indicates, we will be talking about ambulatory care for the next four to five hours if yesterday's practice session is any indication. So you might want to grab yourself a cup of coffee and settle in. Think of it as the Titanic without the special effects. I think the results will be similar.

[Laughter.]

DR. MATHEWS: Over the last several months we've been talking about the BBA's mandate for a prospective payment system for hospital outpatient services. Under this new system Medicare will replace the previous cost-based payment methods with a prospective system under which the payment for a service will be known at the time the hospital provides it. The Congress established the outpatient PPS to simplify outpatient reimbursement, makes payments more predictable, to begin to control expenditures for these services, and to begin to correct the problem related to the beneficiary coinsurance liability.

Most of the outpatient services that hospitals provide can, in theory, also be provided in other ambulatory settings. Historically, Medicare has paid different amounts for the same service depending on the setting in which it's provided. However, because of these payment methods it has always been difficult to determine a hospital's payment for an individual service.

One result of the outpatient PPS is that for the first time this payment amount will be known up front and providers will easily be able to compare Medicare payments across ambulatory settings. As a result, decisions regarding where to provide a service may become more influenced by which setting is the most profitable rather than which is the most clinically appropriate. The continuing integration of providers in the health care market will facilitate such assessments.

Similarly, the Medicare program will be more easily able to evaluate these differences as a prudent purchaser of services. Ideally, Medicare should pay for outpatient services based on the least costly, clinically appropriate setting.

However, hospitals may incur costs that other facilities do not related to differences in the severity of the population of patients they treat, the costs of standby capacity such as emergency services, licensing requirements, and so forth. Failure to recognize these costs could place hospitals at a competitive disadvantage relative to other ambulatory providers. Hospitals may react to perceived inadequacies in outpatient payment rates by shifting these services to other

potentially less clinically appropriate settings or by ceasing to provide them altogether.

To determine the potential magnitude of such incentives in the current system, we have begun to investigate the distribution of ambulatory services across settings and the extent to which differences in Medicare payments may influence the choice of setting. While ambulatory care can be provided almost anywhere, the bulk of Medicare volume and expenditures is in only three settings: hospital outpatient departments, ambulatory surgical centers, and physician's offices. I'll describe these in order of less intensive to more intensive setting then wrap up with our comparative analyses and put some ideas on the table as to where we might go from here.

DR. LAVE: Can I ask a question about this table? Does the outpatient facility and the ambulatory care surgical center also include the physician fee component for the services that are provided?

DR. MATHEWS: No, they don't. To get an idea of the physician practice expense that would be comparable to the facility payment, it's probably something like 41 to 43 percent of that $18.2 billion that you see on the table.

DR. ROWE: There are other differences, Judy. The ambulatory surgical centers are exempt from the Stark II regulations and ownership may be quite different than you see in hospital outpatient facilities, et cetera.

DR. LAVE: I was just trying to make sense of what the numbers were on this table.

DR. MATHEWS: We will finalize it and make them more comparable for the publication.

DR. NEWHOUSE: The 18.2 is supposed to be the physician component that is rendered in the office?

DR. MATHEWS: Yes, it represents the full range of services provided in the office setting.

Let's begin with the physician office setting. Since 1992, Medicare has reimbursed physicians under the Medicare fee schedule. The fee schedule consists of three main components, the key to which is a resource-based relative value scale which reflects the resources required for each service relative to those for all other services. It is calculated as the sum of relative values of three separate subcomponents: the physician work, the practice expense, and the malpractice insurance expenses. The relative values are multiplied by a set of geographic adjusters and a conversion factor to calculate dollar payment amount.

Physicians are paid under the fee schedule regardless of setting. The physician's work and malpractice expense components are constants, irrespective of the setting in which the service is provided. For some services, however, the practice expense component of the fee schedule is reduced by 50 percent when these services are provided outside of the office setting. This is because the practice expense component is assumed to reflect the costs associated with operating the physician's office.

These costs are subsumed under the payment to the facility in which the service is provided when it's performed in an outpatient department or an ASC. Our comparisons focused on the full practice expense component that is paid when the service is provided in a physician's office as analogous to that payment that is made to the hospital or other facility.

In 1996, physicians submitted claims for

nearly 3,900 different services provided in the office setting, including clinical laboratory tests. The distribution of services is concentrated, with relatively few services and procedures accounting for the bulk of Medicare volume and payments. The 10 highest volume services and procedures accounted for nearly 42 percent of Medicare volume and over 35 percent of allowed charges. You have some more detailed tables in your materials.

An intermediate intensity setting between the physician's office and the hospital outpatient department is the ambulatory surgical center, or ASC. Medicare has covered certain surgical procedures in these facilities since 1982. ASCs have proliferated since then. At the end of 1985, there were 484 Medicare-certified ASCs. Ten years later there were nearly 2,400; an annual increase of 18 percent. Program payments to ASCs increased by nearly 14 percent annually during the mid-1990s, and service volume increased by 13 percent annually over this same period.

While the number of facilities is large, their distribution is limited. Although ASCs are located in
all 50 states and the District of Columbia, half of them are located in only six states. The typical Medicare ASC is proprietary, with 92 percent of facilities being privately owned; freestanding, as are 99 percent of them; and urban, with 90 percent of them located in urban areas.

ASCs are limited to a list of some 2,400 approved procedures that they can provide to Medicare beneficiaries. These are inpatient procedures that can safely be performed on an outpatient basis yet which are not frequently performed in physician's offices. They are assigned to one of eight payment groups, each group having a prospective payment rate. This rate is also used in calculating blended payments when ASC surgeries are performed in hospital OPDs, which I'll discuss momentarily.

Although there are 2,400 approved procedures, ASCs only actually provided about 1,100 distinct procedures to beneficiaries in 1996. Of these, the 20 highest volume surgeries accounted for roughly 80 percent of all procedures performed in ASCs, both in terms of volume and payments. Moreover, a single procedure, removal of cataract and insertion of intraocular lens accounted for 35 percent of Medicare ASC volume and over 55 percent of Medicare payments to these facilities.

This cataract procedure is important because in addition to making up the lion's share of Medicare payments to ASCs, it is also the service for which Medicare makes the greatest payments in the hospital outpatient setting. It is also one of the few procedures of any notable volume for which ASCs account for a substantial percentage of the overall volume across ambulatory settings.

While Medicare's payments to ASCs currently make up only a small percentage of its ambulatory care expenditures, two factors could change this situation. First is the rapidly changing health care marketplace, especially the integration of providers that we've seen in recent years.

Second is the hospital outpatient PPS. It's possible that once the outpatient PPS is implemented services may shift among settings in a more direct response to payment to cost considerations. As a result, ASCs could take on a larger role within the ambulatory care arena.

The reason we're concerned with how much Medicare pays for services in physician's

offices and in ASCs is that now for the first time we will also know up front how much Medicare pays for specific services in the hospital outpatient setting.

Hospital outpatient departments are the third and largest ambulatory care setting that we'll look at today. Payments to hospitals make up about 70 percent of Medicare facility payments for ambulatory care. The $20.9 billion in Medicare payments for outpatient services in 1996 represented about 20 percent of all program payments to hospitals. Spending for hospital outpatient services has risen at an annual rate of about 13 percent since 1983.

As I mentioned earlier, the growth in hospital outpatient utilization and expenditures accentuated several stresses in Medicare's payment system. These problems were addressed by specific BBA provisions. Until these provisions are implemented, however, hospitals will continue to be paid under the current complex system. The one you see here represents, keeping with the Titanic analogy, the tip of the iceberg. This is the short form.

A hospital's payment consists of two parts, beneficiary coinsurance and a program payment. Beneficiary coinsurance is 20 percent of the hospital's charges at the time the service is provided except for clinical labs for which there is no beneficiary coinsurance.

Calculating the program payment is much more complex. When a hospital provides an outpatient service to a beneficiary, the charges for the service are accumulated with those for all other outpatient services and are reported on an aggregate basis in the hospital's Medicare cost report at the end of its fiscal year. The Medicare program payment is calculated as the lesser of the hospital's costs, charges, or for ASC-approved surgeries and certain radiology and other diagnostic procedures, a blended amount, net of beneficiary deductibles and coinsurance.

In 1996, hospital outpatient departments
provided about 4,300 distinct Medicare services, again, excluding clinical labs. These services included simple diagnostic tests, outpatient clinic visits, various therapy services, imaging services, ambulatory surgeries, and emergency care. The scope of services has expanded greatly since the early 1980s, reflecting changes in medical technology, clinical practice, beneficiary characteristics, and Medicare payment policy.

Like the other ambulatory settings, the distribution of hospital outpatient services is also noteworthy. Again, a relatively small number of services and procedures account for the majority of Medicare hospital outpatient volume. The 10 highest volume services constituted 45 percent of total service volume in 1996, and the top 300 services made up over 90 percent of total volume and payments. That 300 is a figure just to keep in the back of your mind for a little while.

We wanted to examine the variation in Medicare payment across ambulatory settings and to assess the possible effects of payment on the distribution of these services. We analyzed a number of high volume services and procedures that accounted for the largest share of Medicare hospital outpatient expenditures. The five highest volume services and procedures in each of the four current payment methods together compose 40 percent of total Medicare hospital outpatient volume.

We compared the hospital facility payments for these services, less the formula-driven overpayment eliminated by the BBA, with the corresponding payments to ASCs and physician's offices. These data show that considerable variation in the facility payment does indeed exist

among these settings. In the most extreme case, the median payment to hospitals for some emergency visits is six to seven times greater than the corresponding physician's practice expense payment.

While differences in payments do exist, the payment to the hospital is not always highest, as might be expected. In fact, of the 20 high volume services that I've just indicated, the median hospital payment is higher in only 12 cases. For example, the base ASC rate is higher than the median hospital payment in three of the five ASC surgeries that we've examined here. However, hospitals still provide the largest share of ASC surgeries, providing between 60 and 80 percent of these services across settings.

It is important to keep in mind, however, that the ASC payment estimates presented here and those for radiology and other diagnostic procedures do not include the formula-driven overpayment that hospitals have historically received.

DR. ROWE: Jim, can I slow you down just for a second? You said that the hospitals still provide the majority of the ambulatory surgical services even though there are these 2,400 ambulatory surgical centers.

DR. MATHEWS: That's correct.

DR. ROWE: In the states in which these are prevalent -- since you said of them were in half a dozen states or so. In the states in which they are prevalent, do you know offhand what proportion of the ambulatory surgical services are provided in these centers? Just as a gauge to what, in a fully mature market if these became really prevalent everywhere, what proportion we would see of these outside the hospital, do you know?

DR. MATHEWS: No, sir, I don't, but we do have information available to analyze that and we can report back to you.

DR. ROWE: I think that might be helpful in terms of our predicting where -- and it may be that in fact this is a little over the top in some of these states and that not all of these are going to survive. But it would at least give us probably a maximum outside projection of what proportion of these would migrate out, which might be helpful in some of your analyses and your projections.

DR. LAVE: Another concern that I have in these data is, this is Medicare payment that you have here?

DR. MATHEWS: Right.

DR. LAVE: I'm not sure that's really the relevant payment. I think you may want to look at the Medicare payment including the beneficiary copayment.

DR. MATHEWS: Let me clarify that. When I say Medicare payment, it does include --

DR. LAVE: This does include the cost sharing?

DR. MATHEWS: That's correct. I would differentiate by specifying either program payment or beneficiary coinsurance.

Radiology and other diagnostic services highlight another interesting element of the distribution. That being that there is no corresponding ASC payment rate for these services because Medicare limits ASCs in the services they can provide. Provision of radiology and other diagnostic services is mixed between hospital OPDs and physician's offices. The data do suggest

a tendency to provide other diagnostic services in the physician's office setting.

However, while the practice expense payment for these services is higher than the median hospital payment, the correlation between the higher payment amount and volume does not appear to be especially strong. In those cases where the service volume is more evenly distributed, the services are generally simple diagnostic and imaging tests; plain film x-rays, mammography, CV stress tests, and echocardiographies.

Only for cost-based services such as clinic and emergency visits is the hospital payment uniformly higher than that for other settings. In these cases the volume of the service is almost wholly concentrated in a single setting; a pattern that does not seem to be strongly influenced by payment amount. Emergency services are almost exclusively provided in hospital outpatient departments.

In general, the provision of ambulatory care is currently somewhat segregated by setting. There are a number of possible reasons for this distribution, all of which have implications for rationalizing Medicare's payment for ambulatory care across settings. For example, there is no ASC volume and no ASC payment for most ambulatory care services actually provided because of Medicare's limits on these services.

Clinical practice also plays a role in shaping the distribution of services. For example, true emergency care requires the medical staff and resources present in a hospital outpatient department. Few of these events could adequately be treated in less intensive settings. So we have almost 100 percent of emergency services being provided in hospital outpatient departments.

Conversely, it is not efficient for hospital outpatient departments to provide low intensity evaluation and management or clinic visits. These are almost wholly provided in physician's offices.

Such factors affect settings is also evidenced by the relationships between payments and volume. If the incentive for providing a service in one setting over another were primarily financial the majority of medical visits and hip x-rays would occur in the hospital outpatient setting, yet this is not the case. As noted previously, it is the relationship between payments and costs that is the more revealing statistic, yet we do not have systematic data on this relationship for two of the three major ambulatory care settings we have examined.

DR. CURRERI: Could I ask you about this slide? If I read this right, over 90 percent of new patient visits are in a hospital outpatient and only 9 percent in an office? I can't believe that.

DR. MATHEWS: I was hoping someone would ask me this question because there's an interesting story behind it. This is indeed what the data show. But when you investigate it in a number of different ways, particularly by aggregating all emergency visits, all office or outpatient visits for new patients, and all outpatient or office visits for established patients, if you lump all of those together and compare the physician claims to the corresponding hospital claims, the numbers are a lot closer together than I would expect.

But the distribution of services by HCPCs codes is skewed. In this case, the coding indicates that something like, as you see here, 90 percent of the new patient visits are being performed in the hospital outpatient department. But what's really happening, when you look at the corresponding payment information, and when you look at the distribution of that coding by

hospital, what it seems to be doing is that hospitals are coding emergency visits as new patient visits. And in fact, 35 percent of hospitals use only that code to account for all of their E&M services.

So it's an aberration of the data. It is an accurate reflection of the coding practices that are going on.

DR. KEMPER: Jim, I had a question about the physician practice expense measure in this table and in the other ones. If I understood it right, you said that half of the physician practice expense gets paid by Medicare as a facility-like payment rather than 100 percent of it. Did I understand that correctly?

DR. MATHEWS: Yes. Let me try and clarify that. When a physician provides a service in the office setting, their payment consists of these three components. There is a professional component and malpractice expense. Those are off the table. There is also this facility -- what I, as a hospital person, tend to gloss as a facility piece. This is the practice expense, and it's designed to reflect the cost of doing business: hiring your staff, paying your electric bills, that kind of thing.

When the physician provides a service in the office setting, the physician is reimbursed that full practice expense amount according to the fee schedule. If the physician goes down the street to a hospital or an ASC, that practice expense amount is reduced by 50 percent. The rationale is that the hospital is now picking up the tab for a lot of those expenses that are covered, or that the facility component is designed to represent. They're cleaning the linens and providing the nurses and that kind of thing.

So what we're looking at in these tables is the full practice expense amount that would be paid if the service were provided in the physician's office.

DR. KEMPER: That was my question. You were clear about the payment in the materials. But then it seems to me, when you move the physician around among settings half of the practice expense goes with the physician, and what Medicare pays to be comparable to the facility piece, is only half in the physician's office.

So it seemed to me that these comparisons of facility expenses across settings really only ought to have half the physician practice expense, which would substantially change the comparison it seems to me, because the half that goes with the physician gets paid in any setting. And that makes the payments look even more different across settings.

DR. MATHEWS: That's correct, that would be a valid way to look at it. And if it's the Commission's sentiment, I would be happy to reflect that change.

DR. ROWE: Or both ways.

DR. WILENSKY: I want to think about that a little more.

DR. ROWE: I think it depends on the question you're asking here.

DR. MATHEWS: Right. To the extent that a facility payment, however opaquely, is designed to reflect

-- I don't know if I even want to say this, but reflect the cost of providing the service, I think the more valid comparison is the full amount. If you want to look at payment as an amalgamation of all of these different policies that come into play, then yes, your point is absolutely correct.

DR. WILENSKY: Is there a little more before we open it up? There are a number of areas that we've sort of been asking. If it's just to clarify, that's fine, ask it now. If it's general discussion, why don't we hold it --

DR. MATHEWS: I actually had a fair amount more but I'd be happy to stop.

MR. MacBAIN: I just wanted to clarify a point. If a physician provides the service 99201 in a hospital outpatient department, between what the hospital is paid and the practice component of what the physician is paid, the total facility would be $85 plus half the 13; is that correct?

DR. MATHEWS: That is correct.

MR. MacBAIN: But if the same physician provides the same service in his office the amount is only the 13?

DR. MATHEWS: That's correct. So half of that physician practice expense is indeed a wash.

MR. MacBAIN: It's part of the hospital expense.

DR. MATHEWS: Right. But the hospital doesn't get it. But it is a facility piece that is paid.

MR. SHEA: It's actually in addition to the 85.

DR. MATHEWS: That's correct.

MR. SHEA: The total cost to Medicare would be 85 plus --

DR. WILENSKY: Yes. So if we're looking at what Medicare is paying for the service to occur, it ought to include both components. The fact that it doesn't go -- I mean, who receives it is important to the institution, but it's not the issue for Medicare in terms of trying to look at what it's costing Medicare to have the service performed.

DR. MATHEWS: That is correct.

DR. WILENSKY: That's where, I think to display --

DR. ROWE: It's a different question.

DR. WILENSKY: Right.

DR. KEMPER: They're two different questions.

DR. MATHEWS: After the presentation you might want to discuss that point. If you want to do it correctly, it will involve considerable spinning the tapes to process the information, but we can --

DR. MYERS: Is the new in 201 new to the provider or new to the facility?

DR. MATHEWS: The honest answer is, who knows.

DR. MYERS: Does anyone care is the real question.

DR. MATHEWS: The hospitals don't.

DR. MYERS: Does HCFA? Because clearly --

DR. MATHEWS: No. Both the regulation and the enforcement of coding in the hospital outpatient services is somewhat freeform, I guess.

DR. MYERS: 91 percent of 201s are in the hospital?

DR. MATHEWS: That's correct. But those are not all -- the vast majority of those are not --

DR. MYERS: We know that those are not all new patients either to the hospital or to the

provider in the hospital.

DR. MATHEWS: That's correct.

DR. MYERS: And we know that 30 percent of the hospitals are only using that code.

DR. MATHEWS: That's correct. It's the first one on the list.

DR. MYERS: Something is wrong with this picture. It seems to me that that's glaring out at us in some way that we need to address.

DR. WILENSKY: This is a specific issue we can take up when we talk about the specifics.

Jim, I wanted to ask you something with regard to the ophthalmology, the cataract distinction; 60 percent is in the outpatient and 35 percent -- is this sort of it goes where it goes depending on the ophthalmologist or is there a severity difference? Most of them you comment tend to be, per diagnosis, pretty much concentrated in one or the other. This seemed to be one of the few -- and it happens to be where a lot of the money is -- where, it's not equal, but it's very sizeable, the split between two different settings that are 25 percent difference in payment.

DR. MATHEWS: There are multiple facets to the answer to that question. I can't recall the exact number, but I think the majority of ambulatory surgical centers are owned by physicians or physician group practices, and they are obviously the ones deciding where to perform the service. Concomitant with that, the ASCs, as I understand it, aggressively beat the bushes for patients. They spend a lot of money on advertising, making sure that Medicare beneficiaries know these services are available, sending out shuttle buses to pick up beneficiaries and drop them off back home.

DR. WILENSKY: Do we know anything about severity and/or does HCFA have any distinction in terms of why it would pay differently?

DR. CURRERI: I can tell you I don't think it has anything to do with severity. It has to do with geographic location and physician practices. Most of the ophthalmological ASCs are right in a complex of ophthalmological practices, along with spectacle shops and a whole bunch of other commercial things. And the hospital outpatient by and large are done by hospital-based ophthalmologists.

DR. WILENSKY: I guess this would then go to Jack's question about in an area are there really both, or is it that where there are ASCs doing cataracts, that's where they're done, and where they're done in the outpatient departments there are usually not ASCs doing them?

DR. ROWE: I think so, Gail. I think they -- not to prolong this but to add a little real world nature to this. I think this is the Medicare Payment Advisory Commission and we tend to think the payment is everything, and why is the payment a little different than that payment. It's an incentive and it's going to drive the doctors out of the hospital and into the outpatient or something else.

In my view, most of the variance is not attributable to that because the other part of the equation is volume. And even if the doctor is getting the same or more money doing it in a hospital, the doctor says, I don't have dedicated nurses who do nothing but this. It takes three times as long to do a case. You can't get the operating room on time. There are too many other things that are going on that are bumping me from the schedule. All the employees are in the

union and they're on strike.

I'm going to go to my ambulatory surgery center and I'm going to do six cases before noon. Even if I get paid less per case, my life is simpler. I know when I get there they're going to start the case. And the same nurse every day, all she does is cataracts.

DR. WILENSKY: Not only that, but a lot of times it's doctors owning the ambulatory surgical centers. It gives is a whole new different --

DR. ROWE: So there are a lot of differences, and we shouldn't get so focused on the modest financial differences that we think that's driving this. I think that the equation includes other factors which, when you add the volume and other things, might smooth out some of these differences.

DR. WILENSKY: I think the financial factor is having an important effect, but it really has to do with the ownership of the ASC.

DR. ROWE: And the way it's run.

DR. WILENSKY: And the way it's run. Yes, definitely.

DR. ROWE: And the doctors who own it feel that they can run them for the doctors, not the hospitals.

DR. KEMPER: But I think just to follow up, Jack, on the financial incentives can matter by shifting patients among settings. But the other way which maybe is more potent is determining where the ASCs develop. I guess the question that struck me is why is it that in these six states they've grown so fast, and are the incentives different in those states than they are in other states?

DR. ROWE: Well, there are CONs in certain states.

DR. KEMPER: So it's regulatory.

DR. ROWE: Let me give you an example. I don't think it's a rural thing or it's not -- I think there are hospitals that are establishing these across the street in partnership with doctors, and as long as the hospital has less than a majority interest it's not a union shop.

DR. WILENSKY: We have some examples in this area.

DR. ROWE: So it can be exactly across the street. I mean, the issue is not necessarily areas that are underserved. There are other factors that go into the configuration of these things, all of which are important.

DR. MATHEWS: One of the things that we will definitely look at is the question of geographic availability that was raised. We also, as I work through this, will put on the table the idea of looking at patient characteristics and determining if the patients are somehow different, whether different populations receive the same service in one setting or another. But the ownership thing is a tough nut to crack.

DR. ROWE: I think the bottom line here for you, Jim, in the preparation of this material is that while our concern primarily may be with respect to payment, that these discussions and chapters become more robust if we at least place payment in the constellation of a variety of factors that might influence behavior, et cetera, that we could list. We don't have to go into them in any great detail, but at least so that the reader doesn't get the sense that this is the dominant factor. There are these other considerations.

DR. CURRERI: Is there a way to somehow -- I haven't really thought this through -- but

it occurred to me in reading this material that somehow we need to apply a risk adjustment to populations that are going to different settings. Because it's conceivable to me, at least some of the things driving certain codes toward hospital outpatient is because of greater severity of illnesses of patients that have those codes.

DR. ROWE: I think that was Gail's question.

DR. CURRERI: These figures just don't separate that factor out to me very well.

DR. WILENSKY: If that occurs, yes.

DR. CURRERI: If that occurs, right.

DR. MATHEWS: I'm willing to concede the possibility but we haven't yet conducted the analysis that we need to do. One of the things that we might look at are whether patients who have an inpatient admission for some condition receive the majority of their ambulatory services in an outpatient department because of heightened frailty or something like that. Whereas a person who receives the same service in an ASC, that might be the only thing they have in an entire year. They walk in and walk out.

But it's one thing that we will try and investigate and report back on whether or not some sort of case mix adjustment is warranted.

DR. ROWE: I think when you do it, from a clinical point of view, assume that the disease that's being treated is the same in all the cases, like cataract, and that the factors that might influence the physician's decision as to the place of the cataract removal is the comorbidity. So if there's a patient with heart disease and arrhythmias and diabetes who's had a stroke and who needs a cataract removal, the doctor is going to say, for some reason I just feel a little more comfortable having you have this in the hospital as opposed to in the ambulatory surgery center. I'm just not sure how it's going to go and I want to make sure there's a cardiologist around if we need one, et cetera.

So that the cataract removal is the same, the diagnosis is the same. It's the comorbidity that I think might influence. And one easy way to do that as a proxy for that is just by age. You might just say --

DR. WILENSKY: So we just have them go to the Medicare files. That's actually one of the analysis that could be done. We could actually say, it's an interesting hypothesis. It's either true or it's not.

DR. ROWE: That would be great.

DR. WILENSKY: It's actually a search that you do.

DR. MATHEWS: We could look at a population at all of the patients who got their cataract surgery in an ASC and see what else they had done that year and where it was, and then compare that same --

DR. ROWE: Sure, if they had a cardiac bypass or they had a pacemaker or whatever. I think that would be an interesting -- I think this gets to Bill's question, right?

DR. CURRERI: Right.

DR. ROWE: That's what you mean by frailty. Not that the diagnosis itself is different, but that --

DR. WILENSKY: We don't have to proxy age. You can actually look at what they had -

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DR. ROWE: So we've actually found something we can do.

DR. LEWERS: I want to come back to what Bill is doing because I think there's a quality issue there that's very important. But I need some basic help -- I need a lot of help. I don't understand this chart at all. There are two or three of your other charts that I don't understand. You talk about procedures provided in hospital outpatient departments and then you put physician office. Are you saying physician's offices that are in hospital outpatient departments? Because if you are, then those numbers have to change completely. I just can't track this chart at all.

I think also in some of the outpatient settings there is some regulation, rule, instruction or something -- Gerry said he heard this as well -- that requires the coding in that manner.

But this chart doesn't mean beans to me. I would charge a 99201 if I got $85 instead of a 213 if I was instructed, because I get $54. And then that's called fraud. So this chart confuses me to no end, as do a couple of the others that I let slide figuring we'd get them later. That's probably your Titanic theory.

DR. MATHEWS: Let me try and clarify what this chart is showing. These five E&M codes that I've listed here are the top five E&M services that hospital outpatient departments provide; one, two, three, four, five in order. If you look at those five services and then look at the provision of those services across all settings, in the first case, 99201, hospitals are coding that service 90 percent of the time relative to all of these other services.

Also one of my colleagues in the audience from AHA has informed me that you are correct, there is a specific Medicare instruction that does direct hospitals to use that code.

DR. LEWERS: But where does physician office come in? Because your title is either wrong, because you're saying in hospital outpatient departments. Are you saying the physician's office is in the outpatient department?

DR. MATHEWS: No.

DR. LEWERS: Or are you comparing --

DR. CURRERI: He's comparing the --

DR. WILENSKY: No, he's looking at the 99201 code.

DR. LEWERS: So your title of your chart needs to be changed.

DR. WILENSKY: Every instance of 99201; isn't that right? Of the 100 percent of the 99201s, 91 percent are in the hospital, and 9 percent are in doctor's offices.

DR. MATHEWS: That is correct.

DR. ROWE: But the title of the slide says provided in hospital outpatient departments.

DR. MATHEWS: And relative --

DR. ROWE: Ted thinks, therefore, all this data is provided in hospital outpatient departments.

DR. LEWERS: Right, that's what I was trying to clarify.

DR. MATHEWS: I will increase the accuracy of the title.

DR. WILENSKY: Peter and Spence, is this again clarifying as opposed to more general issues?

DR. KEMPER: No, it's more general.

DR. WILENSKY: Why don't we wait on the more general issues.

MR. JOHNSON: Clarification on the study. Do they show complication rates? Can you track complication rates by freestanding versus hospital?

DR. WILENSKY: What we're talking about is -- we can talk more seriously about how we would do -- I think the issue that's raised is one that we ought to follow up on a study. But the comment, the reference to doing a study is the Medicare patient record files, the MedPAR files that are available will show all of the encounters during the year for a particular patient. Therefore, when we have somebody who is in an ASC, we can go and see what else happened to them during the year so we can get a sense of comorbidity that would be much better than just doing an age correlate.

DR. LAVE: Could we go back two years or a year and-a-half?

DR. WILENSKY: The answer is yes, but it gets trickier to match the patient record numbers. I mean it's easier -- the MedPAR file data is usually on a -- I don't know. I assume that -- is it linked?

DR. NEWHOUSE: Yes.

DR. LAVE: I would recommend if you could it to go back --

DR. WILENSKY: Joe says it's linked now. As long as it's linked and we don't have to do the link, the answer is yes.

DR. MATHEWS: Just one other point of clarification on your point in terms of the relative payments by code that you see here. This is, although I've pitched it this way, it's not a static thing. The hospital does not code that service and get paid $85 versus $54. The hospital could literally charge $1 million for this service and get $200,000 from the beneficiary. This simply reflects common practice among hospitals. There's no fixed amount yet that the hospital would get paid for coding a given --

DR. LEWERS: I know that.

DR. MATHEWS: The data that we've presented here provide an initial assessment of the differences in payments and utilization of ambulatory care across settings. Although a wide range of services can be potentially provided in all three settings, actual volume is concentrated among a relatively small number of services within each. Further, the number of services that are distributed across all three settings is also small. Where overlap does occur, the services tend to be relatively simple diagnostic services.

Finally, we confirmed that there is indeed considerable variation in payments across settings. However, there is also substantial variation in the hospital setting. I didn't give you those numbers but we can talk about them later.

Moreover, the variation in payment among settings is not always skewed in favor of hospitals as has generally been believed. These data should serve to assist policymakers in rationalizing Medicare's payment for these services that are common among the settings. It is important to keep in mind, however, that the data reflect a multitude of factors including clinical practices, coding and billing practices, geographic availability of settings, beneficiary characteristics, and Medicare's existing payment policies.

The appropriate payment for an ambulatory service in a given setting invokes a larger discussion of the rationality of Medicare's various payment systems for these services. To a great extent, such a discussion depends on knowledge of the relationships between costs and payments. There are large gaps in the available data that may prevent this goal from being achieved in the short term.

For example, the Commission has supported the idea that there should be no financial incentives that could undesirably influence clinical decision-making. In other words, that the relationships between payments and costs of ambulatory services should not vary across settings. However, systematic and comprehensive cost data are not readily available for physician's offices or ASCs. We've also seen that even the available hospital data requires substantial adjustment before they can be interpreted correctly.

Our data suggests courses of future investigation as the Commission continues to recommend improvements to the hospital outpatient PPS and ambulatory care payment in general. For example, the distribution of services in any of the three major settings that we examined is interesting. In all three cases, a relatively small number of services accounted for the bulk of Medicare volume and payments. If one of the goals of the outpatient PPS is increased simplicity, this could be achieved through coverage as well as through payment, and perhaps the low volume services warrant closer examination.

Another area of interest involves the comparison of relatives across ambulatory settings. That is, how does the ranking of services and procedures in one setting compare with the rankings for the others? If there is some consistency in the rankings, payment policies could be more explicitly connected across settings. While we do not have systematic cost data for all ambulatory settings, an analysis of payment data may still provide valuable information.

A third topic worthy of investigation relates to a more detailed investigation of factors that contribute to higher costs that may underlie differences in payment. For example, why are hospitals costs higher than the corresponding ASC payment rate for many services? Are these costs due to regulatory requirements faced by hospitals but not other facilities, higher standby costs that hospitals incur, or differences in the mix of patients that each facility treats?

Finally, in the long term, the rationality of Medicare payment for ambulatory services turns on standardizing variation between payments and costs among settings. As a result, the Commission may want to think about the feasibility of obtaining and analyzing systematic, procedure-specific cost data for physician's offices and ASCs, notwithstanding current efforts in the physician realm. Until we have this information, the current payment and utilization data cannot provide all of the answers to our questions, but I will continue to try and answer yours.

DR. CURRERI: I want to come back to something I think Jack originally mentioned. It is interesting to me to see what kind of a factor, or try to assess what the financial factor is in terms of determining settings. My own bias is that it probably isn't a very important factor, but we don't know that. But it seems to me we have a real neat opportunity here to look at this prospectively. Even though I think it's a bad idea, but the BBA does mandate the institution of prospective payment at different times for all these settings.

So that you really have an interval there that if you're looking forward and study you could

see essentially if there is any effect during that one-year difference between say ambulatory surgical centers and hospital outpatients. It's probably a one-time, unique opportunity to see whether or not finances do drive the choice of setting. So I think you really ought to be thinking about that right now because we're going to be starting January 1, '99.

DR. MATHEWS: Right. Also the Commission will have a chance to take another stab at this using some real numbers from HCFA in terms of the hospital payment. We're anticipating their NPRM on the outpatient PPS to come out sometime in mid-May, and we can get those numbers to you so you can make some real world comparisons.

DR. WILENSKY: Woody, do you have a question on this point?

DR. MYERS: On this issue. Though it doesn't make a lot of sense to do it unless you overlay it with the changing CON regulation with respect to ambulatory surgical centers. States are in various stages of having changed those regulations. So just because a state today may have a relatively open regulation, a year ago they may not have. So you haven't seen a ramp up of centers yet. That might be in progress and, therefore, you would make a wrong interpretation as to what is actually happening in a state. So it will take a detailed look at what CON is like in those states as well as looking at the other factors.

ramp up

DR. KEMPER: I just wanted to agree with the earlier comment that looking at differences in the actual service delivered and the risk of the patients across the settings is very important. The reason is, it seems to me it very much affects how the payment rate ought to be set. If it's literally the same service for the same risk patient across settings, then shouldn't the payment be the same across settings?

You argue that payments should be related to costs. That seems to me to be valid if in, say hospitals, high risk patients are treated and they're systematically different and you need the standby emergency room and all the things that a hospital brings. Then you're really comparing apples and oranges across settings and there's reasons to have different payments across settings.

On the other hand, if it's really a standardized service across the settings, and the settings exist in the community -- that's another important piece of it -- what's the justification for paying based on cost rather than on the service?

You've come out pretty strongly on paying in relationship to cost. Perhaps because you implicitly have a judgment that the services are very different across settings. But it seems to me it depends on the service.

DR. MATHEWS: Right. It wasn't my intention to sound so strongly that payment should simply reflect costs, but rather as you point out, that these costs have to be defensible in terms of some sort of differentiation of the service. Even though it has an identical code across these settings, that somehow it is qualitatively different in terms of what the beneficiary is provided, what the beneficiary receives.

DR. WILENSKY: Peter, I think you just asked the economist's question around the table. But would not the presumption be --

DR. KEMPER: I apologize.

DR. WILENSKY: Several of us have had this discussion of why are we presuming equal

space between cost and payment as opposed to low cost unless otherwise justified. So it would be to the extent that a risk adjustment, because of comorbidities or because of differential severity of the particular, and/or if you want to explicitly recognize a reservation price. That there are some costs that you want to explicitly recognize that might be present in a setting.

But what had disturbed me was the presumption that we ought to accept the price as opposed to the presumption we ought to accept low price unless otherwise acknowledged that there's either a risk adjustment or some other factor that would allow for a different price.

DR. KEMPER: But I think the other factor that we should pay attention to is whether the service would be available otherwise.

DR. WILENSKY: Availability, yes.

DR. KEMPER: So if there are no ASCs in a particular community, then it might not be possible to get it at -- if the ASC were at the lower rate in a lot of places.

DR. MATHEWS: One of the things that I mention in the draft chapter here is that certain, what I would define as low intensity services do seem to be fairly evenly distributed between the hospital outpatient department and the physician's office. For example, chest x-rays or a 12-lead EKG. Those are the kinds of services where maybe we could benefit from a clinical opinion as to whether or not there is any qualitative benefit that the hospital provides in delivering that service relative to a physician's office.

DR. WILENSKY: You might want to look at cataract while you're doing this, which is a little more costly.

DR. MATHEWS: Right.

DR. LAVE: Yes, I really want to follow up on this presumption. I've been sitting here looking at these data and puzzling, and puzzling also about the implications of a decision that we might make. And that is, there are sort of two things that come to mind. I'm looking at all of these low level things. Suppose that it actually was true -- let's just say that these numbers -- suppose that it cost the hospital $30, or whatever the number is, and the physician, half of that. And the hospitals were reasonable and we decided not to pay them the $30. What would that mean for patient care?

Because if the physician is doing -- that means you have to choose a physician who in fact has these things in their offices, and they might not all do that. And I'm just not sure, given that the hospital is used as a site for the major provision of care, I'm not sure what the implications are of that decision.

Where the decisions here are that not all physicians -- if you did this then you would have to go to a physician who had a mammogram in his or her office, otherwise this would not be provided. So that would be your choice about where to go. It's not so likely to me that the physician would -- the referral patterns would be somewhat strange.

So I think that there may be some implication of a decision that says you really want to pay the lowest price for all of these things without thinking about how the overall hospital outpatient department has developed as a service source for major different points coming into it, somewhat different than a physician's office.

Now I know I'm being extraordinarily inarticulate and maybe somebody else -- everybody

else may think this is crazy. But I think the hospital does play a role here that we really ought to think about, if it turned out it could not -- now this is the -- it could not provide a service at the price that we were willing to pay for it.

I have a question, one question --

DR. WILENSKY: Judy, can I, just on this question on this issue.

DR. LAVE: Yes, I just think that we have to think this one through a little carefully.

DR. WILENSKY: Let me just -- I don't know whether this is something as -- because this is clearly a chapter that we will need to see later in the month in the next meeting. If there is an indication how much -- I don't know that you can do very much in this two-week period. But what we would like to do to get ready for our next round of comments next year on some of these issues of not of where this care is occurring. Because while I think you've raised a legitimate issue, the fact is physicians by and large are not any longer practicing as solo practitioners. They are frequently in either single specialty or multi-specialty groups within or without a medical park.

So this issue of exactly what is it that we're suggesting if we were to say, pay at a lower price unless there's something about the patient or availability in terms of ASC, at least about saying, how would we want to go about assessing whether we would have generally adverse impacts is not just, does a physician frequently have the piece of equipment in his or her immediate office, but where is that person practicing.

DR. LAVE: I agree but -- I think that's true. I also think that we have to be very careful about the extent to which these integrations are or are not taking place. I mean, the world is very different. America is very different in terms of integration of physician practices, development of group practices, the extent to which in fact this has really happened.

The second thing that I'm very curious about is, do we know what a hospital outpatient department is? I don't know whether that is actually terribly clear. When is a hospital outpatient a hospital outpatient department? I would like to have some discussion about that because it's not clear to me that all this sort of integration that's taking place, whether the hospital outpatient department, which is what we sort of think is a hospital and then next door to it, attached to it is this outpatient department, whether that is what a hospital outpatient department is anymore. I think that we really have to think about that concept in the construct of what we're doing.

The third point that I would like to see us think about, again we think about -- we all talk about excess, about standby capacity and the hospital outpatient departments maybe need to have excess capacity. I would like to sort of think about it as excess capacity in some things. It doesn't have to have excess capacity for chest x-rays, and it doesn't have to have excess capacity for mammograms. It might have to have excess capacity for something.

Now if it has excess capacity for something, then it seems to me that the issue then becomes the allocation of overhead and how much of that something. So we have to worry really about the structure of the costs that may emerge, and it may be quite different from what we are observing. If one thought about the difference between things which are really not terribly fixed in terms of their costs and there really are no excess capacities, and then there are things for which in fact.

This would mean that if there are some things that have excess capacity, that the costs really ought to be borne by those things and we can observe what they are. So those were my thoughts.

I mean, the excess capacity thing, if you look at all the stuff, it can't be an issue. You wouldn't have -- there's no reasons to have mammograms on standby capacity.

DR. WILENSKY: Did you want to comment, Jim?

DR. MATHEWS: Just I don't envy the Commission for having to make these decisions.

DR. ROSS: Judy, I just wanted to clarify, when you were referring to excess capacity, you're distinguishing between excess and reserve?

DR. LAVE: I meant to talk about reserve and standby. Woody just said to me an ER has a lot of trauma rooms which aren't being used. Well, you don't want to reallocate some of those costs to your -- you want to make sure that the costs, the standby capacity, the reserve capacity, those costs get allocated. And you may see quite different shifts in the price structure that would arise if you did that.

MS. NEWPORT: Just a clarification of my understanding of this. You make a statement in your paper that hospitals don't know in advance what their payment, their cash flow I guess, is in this area and I'm a little puzzled by that since it's the claims submission. Is that because of the hospital payment system, it flows up or --

DR. MATHEWS: No, the way it works is hospitals are not paid on a disaggregated basis by the Medicare program when they provide these services. What happens is they send the bill to the beneficiary. And it's got charges on it and the beneficiary pays 20 percent of those charges.

Then that bill gets sent to the Medicare fiscal intermediary who rolls it up into an ongoing provider statistical and reimbursement system. They're aggregated and the hospitals receives, I think payment six times a year or quarterly, something like that, on an aggregate basis. Then those interim payments are compared with the hospital's cost report, which is the final fiscal year submission.

So we're talking about hospital payments being calculated in the aggregate. Historically, it has been difficult for both the program and hospitals to determine what they would be paid by Medicare for providing a given service.

I know we will have some members of the audience who will come up and comment on this as well.

MS. NEWPORT: Forgive me if this is pretty elementary, but the other statement you make in here is, beneficiaries will be liable for nearly 50 percent of the total payments and we've discussed that before. Have you looked at the percentage of beneficiaries that have Medsup coverage and how that might affect --

DR. MATHEWS: Most of them do. Between Medigap and Medicaid coverage I think you're talking well over, or in the low 90 percent range, beneficiaries have this additional coverage. The problem is they're starting to see indirect effects in that the premiums for Medigap are starting to increase at double digit rates annually. I think we are just now beginning to see that wave starting to crest.

MS. NEWPORT: I think it's an interesting point in terms of what the cost shifting or

price sensitivity would be on this because of that. Maybe for a later date. Thank you.

MR. MacBAIN: A couple things. One is I just wanted to clarify. In your argument of payments versus cost are you suggesting we should seek to equalize profit margins across settings so that the profitability does not become a factor in how the decision is made among what setting to use?

DR. MATHEWS: I suspect it appeared that way in my paper. But a few days ago I sat in on a panel discussion by one of the professional groups in town and the agenda for their discussion was sent out on their letterhead, and at the foot of the letterhead in very, very fine print there was a line there that said, all opinions expressed herein are subject to change without notice, and I will avail myself of that.

[Laughter.]

DR. MATHEWS: I guess in my own mind that I would put on the table for your consideration, not as a statement of fact but just something I've been thinking about is that rather than look at gross relationships between payments and cost as a benchmark of what we should be doing across ambulatory settings, but rather standardizing the measure of costs that you want to be reflected in your resulting payment.

If you want to include standby capacity as one of the fields, one of the categories of cost that you will recognize, and in a less intensive setting, the value, the absolute number in that field is zero, you've still standardized the measure even though the absolute number is more in one setting than another. And that's something the Commission might want to think about.

MR. MacBAIN: Another point is really to underscore something Jack said earlier. That is, for surgical procedures the person who makes the decision on the setting is not necessarily influenced at all by HCFA's facility payment procedures. It's much more a function of convenience and volume. That's certainly true with cataract. Even ownership is, I would suspect, a much lesser factor than the volume factor. If you can do a larger number of surgeries in a day in an ambulatory surgical center, that's where you'll do them, regardless of how the payment is structured.

In the spirit of directions for the future, that's a direction I'd like to see us look at is, who are the key decision-makers and what do the current payment policies provide in the way of incentives or disincentive to choose the optimal setting, optimizing quality and efficiency?

Then in that context, to go back to one of Judy's comments, which is how does that then change as ownership becomes concentrated and we move from independent ambulatory surgical center, hospital and surgeon to a holding company that owns the hospital and the surgical center and the surgical group?

DR. MATHEWS: Right. Yes, I would definitely concur 100 percent that Medicare's payment methods aren't the driving force here in determining where a service is provided. But in some cases they very explicitly can't -- they indicate where it cannot be provided. Clinically it might be determined that the best place to do chest x-rays is in the ASC, and guess what, can't do them there.

DR. ROWE: I had a couple comments. I think the concept of the profit being the same in all places implies to me that there might be a day in which revenues actually exceeded

expenditures, absent philanthropy, which does has made my day. Just that concept would be new in my experience.

[Laughter.]

DR. ROWE: But anyway, I'd say a couple things. One is I think that when you see all those ambulatory surgery centers crop up in certain areas you can't help but wonder whether or not that there's purely a financial motive and that there may be a quality problem with respect to overuse. That maybe more of these procedures are being done for Medicare beneficiaries than really need to be done when you see the dramatic proliferation of these. That's the way I feel anyway, a question. I'm not suggesting the answer.

And we have a terrific advantage here since there are a certain number of states that have a lot of these and certain states that don't have many of them, and the procedure that's done, cataract, presumably occurs at the same incidence by age in populations across these different states. People in California I don't think get more cataracts than people in Florida or people in New York or whatever, or maybe they do.

DR. CURRERI: No, that's not true. People in the south have a much higher incidence of cataracts.

DR. ROWE: Okay, but there are different southern states that don't have any of these and people -- so you could correct for UV-A damage and things like that. I think it would be interesting to look over time to see whether the number of these procedures that's done in a population of beneficiaries has been influenced or not by the --

DR. WILENSKY: You're presuming though that when you have a high ASC incidence that you don't have a lower outpatient; is that correct?

DR. ROWE: No, what I'm saying is --

DR. WILENSKY: Or you want to look at that.

DR. ROWE: I think the question is, are we migrating more of them from the hospitals to the ASCs, or is the tide rising -- are there just --

DR. WILENSKY: I assume that is what's --

DR. ROWE: I assume that's what's happening too, but I think it's worth asking the question.

DR. MATHEWS: I have some information I can bring to bear on that. First and foremost, we don't know what the right number of cataract surgeries is supposed to be.

DR. ROWE: Right. Maybe more is better.

DR. MATHEWS: Second, there is an element of the "if you build it they will come" scenario here. If you make these services more available on a less intensive basis, more beneficiaries will avail themselves of this service. A beneficiary who wouldn't want to put up with a two-day inpatient stay to get their cataract done, may well do it if they can walk in and out the same day and write a check for $200 to cover it.

DR. ROWE: Right. That happened with laparoscopic cholescystecomies.

DR. MATHEWS: Right. Third, it is very likely that although the volume of this service has indeed increased, possibly as a result of making it -- just by virtue of making it more available. It is also clear that

I think the program has bought something by doing so, because 10, 15 years ago this was exclusively an inpatient procedure.

I looked into this. There is still a DRG for cataract surgery, and unadjusted base operating payment rate for this procedure in 1996 was something on the order of $2,000 for the hospital. During that year the hospitals did about 2,500 of them on an inpatient basis. During that same year across ambulatory settings they did 1.5 million of this type of cataract procedure.

So even though the payment would still --

DR. ROWE: It's still high.

DR. MATHEWS: It is high in the hospital, this procedure has migrated almost completely to the outpatient setting at a much lower cost.

DR. LAVE: Can I make a comment on this, Jack? And that is that one of the things that we have to remember is that there really was, about five years ago, a very large research effort that looked at whether or not physician ownership of different technologies was positively correlated with those technologies. And the data, maybe they weren't done correctly, but the literature overwhelmingly suggested that it was highly related. You were much more likely to have a CT scan if your neurologist had a CT scan in his office.

So I think that there is some historical precedence for Jack's hypothesis that there might be some overall relationship between these two.

DR. ROWE: Right. It sounds like Jim has thought about this already. But the last thing I would say is I think that in addition to --

DR. WILENSKY: Wait a minute. Can I just --

DR. ROWE: Please.

DR. WILENSKY: There is no question about the studies you're referencing, but the ASC is a little more complicated. Unlike --

DR. LAVE: But the ASCs for cataracts are owned primarily by ophthalmologists. So that in that sense, the analogy is comparable.

DR. ROWE: It's one thing to say, you have a headache, let's do a CAT scan. It's another thing to take somebody's cataract out.

DR. LAVE: But there's a condition of ripeness, is there not? I mean, there's a fair amount of judgment over how ripe the cataract has to be before it is in fact removed.

DR. ROWE: If that's the case, everybody is going to have theirs out early and then --

DR. LAVE: Maybe. But you could die before it ripened.

DR. ROWE: In addition to case mix or comorbidity, and backup, standby, and licensing and regulatory you mentioned early on -- I was happy to see that -- there might be one other one. I don't know if this is a real one or not, but let me try it and see if it makes sense to anybody.

You might be able to have services outside the hospital at a relatively low cost that are individualized, discrete services. But it might only be in the hospital or some other ambulatory place that has this capacity where you can get certain interdisciplinary procedures done.

For instance, if you want to just do it at some low rate, all providers get the same, you would go and get your mammogram at an ambulatory radiology program where they would then find a lesion and put a needle in it to locate it. Then you would have to put your clothes on, get in

a car, drive to the ambulatory surgery center with this needle in your breast and they'll go and have an operation where somebody then takes out that lesion, which is hopefully benign.

That's not the same as having it in a place where you have all this stuff at once, because there are a bunch of procedures that require multiple disciplines, whether it's radiology or angiography or surgery or whatever, all sort of in the same place at the same time in order to get it right. I don't know how common that it, and I bring it up only because I've recently got complaints from patients that after they have the needle put in their breast they have to go across the hall to the operating room and they don't think that's private or appropriate. So I was thinking when I heard Judy talking about somebody having to get into a car.

So I don't know if that's relevant or not, but there's something about accretion of resources that at some point adds some value for some procedures.

DR. MATHEWS: I think it is a relevant and valid possibility. I don't know how we could investigate it in a quantitative basis.

MR. SHEA: Just on this point. I think what came to my mind before when Judy was first talking about there's a relationship issue here which probably is very difficult to quantify or analyze even. But the fact that it might be lower cost in one setting may have to do with the proximity of complex standby capacity, and that's a real factor in town X, Y, or Z. It seems to me that even if we can't clearly quantify it we need to keep it in mind in this analysis and not just start saying, we'll just judge it flat dollar for flat dollar.

DR. LEWERS: But Jack's point though is not exactly right because you get a mammogram that's basically a screening, even if it's a diagnostic mammogram. The second procedure of localization and removal is on another day. Rarely ever are you going to have those done -- so you could have the mammogram done as a diagnostic or screening procedure in one facility. Then you're going to have to change that facility, and it won't be the same day.

DR. ROWE: I think that's a good point, Ted. I'll accept that. And there may be other examples we could come up with. I don't know how big a deal this is. I was just trying to think about the list of things to consider. But I think that's valid.

MS. ROSENBLATT: I have three points. One is, several people mentioned the risk adjustment and comorbidity issues, and I think one of the problems in looking at the list of the common procedures is that they're all these real broad procedures like office visit, emergency room visit. And if it's difficult to get into comorbidity, one way of just looking at that is there a way to do like a double sort of the procedure, and then secondarily, the most common diagnoses? Just an idea.

DR. MATHEWS: Yes, there is. As a matter of fact from what I understand about HCFA's upcoming proposal for the outpatient PPS that is exactly the way they plan to classify and stratify these sorts of visits. That the HCPCs coded visit will be the first order stratification, and then it will be subdivided according to the admitting or the presenting diagnosis.

MS. ROSENBLATT: The second point I think Jack and Janet touched on this, but the fact that there are all these other factors that influence the choice of setting. In commercial insurance, one of the things that will influence choice of setting would be what is the impact on the beneficiary. I think people have been hinting that because of Medigap you don't have that.

Those that are covered, the choice of setting doesn't matter.

But I wonder if the typical beneficiary even knows that there might be a big difference in the copayment to them. My guess is they don't know, because for most of them it's paid for by Medigap. They don't even know that there's a difference.

DR. MATHEWS: Right. I did a little bit, a very cursory literature search on this, four studies on beneficiary choice of setting for these services. The only thing I could find was something from way back in 1982 and it was co-authored by Stuart Altman who used to be in these circles, and the results indicated that the vast majority of the time the beneficiary was not given a choice as to where the service would be provided. Now admittedly, it was a different world back in 1982, but there isn't much out there right now that we can latch on to.

MS. ROSENBLATT: Then my third point was, and this is probably an impossible study but to me it would be an interesting study, is if there was a way to compare where you're looking at say 91 percent in hospital, 9 percent physician, what would that percentage split look like if you looked at the world of Medicare risk, for example? Would it be very different? My guess is there's not data available to do a study like that.

DR. MATHEWS: Right, that's the managed care encounter data problem, and that's someone else's world.

DR. NEWHOUSE: First, just a question. Setting aside the cataract example, how does private insurance in the under-65 market handle payment? Do we know anything about that?

DR. MATHEWS: I don't think many of them are done.

DR. NEWHOUSE: No, that's why I want to set aside cataracts. But obviously they've got an issue of how to reimburse hospital outpatient, ambulatory surgery center, et cetera, for other procedures.

DR. MATHEWS: I don't know.

DR. NEWHOUSE: So we should find that out I think.

DR. MATHEWS: Yes.

DR. NEWHOUSE: Second point, on the issue of the margins versus the cost in terms of the larger question of how to think about the question. By and large, I would say Medicare in the rest of the system tends to opt for a fixed payment that is fairly independent of facility. What I have in mind is the PPS pays generally the same amount for any scale hospital, whether you have a 50-bed hospital or a 300-bed hospital, with a kind of fix for the access issue on sole community. The RBRVS pays the same both for work and practice expense whether you are a solo or a 20-person group, which clearly could have quite different levels of expense.

So there is certainly ample precedent in general Medicare philosophy for paying the same amount to facilities that have, or providers that have potentially different costs.

DR. ROWE: Joe, would that assume therefore, using that analogy about how they pay the hospitals, that if an ambulatory care setting served a disproportionate number of underprivileged or uninsured individuals, or if there were graduate medical education activities going on there that you would then, just like in the hospital example, you would have those payments go to the ambulatory surgery center to supplement --

DR. NEWHOUSE: That's a good question.

DR. ROWE: That's how they balance -- not all hospitals are the same, but those are the mechanisms we use to --

DR. NEWHOUSE: That's why I said with some glosses. I would put the disproportionate, some of that in the same category as I put sole community. But it's a kind of imperfect fix-up if you said -- but to go another way. The general philosophy has not been to equalize margins. It has been to pay a fixed amount across different providers with some patching around the edges, I would say, for some of, like sole community, GME.

DR. ROWE: It's a minor issue.

DR. NEWHOUSE: It's not so minor quantitatively.

The third point also goes to the margins, but it's cost. Costs are, I don't think are -- the observed costs are not given necessarily by -- or what we observe is not necessarily the minimum cost, let me put it that way. You said, if you build it, they will come. I would say, if you reimburse it, costs will rise.

[Laughter.]

DR. NEWHOUSE: We see, for example, on the AAPCC, the high cost counties are providing more benefits. If you said, what is the cost of a Medicare risk plan; well, it depends on what we reimburse.

Moreover, in this particular domain of the outpatient department, as you showed we had essentially a system that had a large element of cost reimbursement in it. Or put another way, there were incentives to raise charges, and we reimburse the lesser of charges or costs, costs could rise.

Another way to look at it then is that because the inpatient side was set by PPS, hospitals had a large incentive to shift any cost they could shift to the outpatient side and show that as an outpatient department cost. In which case the cost -- if we were going to use a cost system we would, I think, want to use the incremental cost of providing the service in the outpatient department and not some concept of average for shifted cost.

The final point is in response to the discussion we had on comorbidities and risk adjustment. This is, I think, a potentially enormous issue because it not only applies here, it applies within the physician office setting potentially, or at least seems to me it should. And it seems to me analogous to the debate we had a decade ago about did DRGs adequately handle severity for -- do teaching hospitals get more severe cases within DRG, where we by and large have punted.

I certainly don't mind raising the issue, and maybe we have comorbidities on the DRG side in terms of the -- and maybe we do something kind of fixed like that here. But my sense is that HCFA is already drowning in all the mandates and the notion that they're going to do an effective risk adjuster for practice costs, well, maybe sometime in our lifetime. But that doesn't seem to me to be a practical possibility. And if it is a practical possibility, as I say, it has a lot of ramifications beyond the question of how to reimburse outpatient departments.

DR. WILENSKY: Let me pause just for a minute and tell you where we're heading in terms of the rest of the morning. I have Ted, Peter, Gerry, Bill MacBain, and Spence. I think that will take another 10 minutes or so. As is obvious, we have another major section that was

scheduled for the morning. We are going to move it until 3:00 this afternoon, since we have two outside guests that are going to be our first session after lunch. Depending on the time, since we have had a substantial amount of time that was allotted for the lunch and executive session, we are going to take up the BBA implementation schedule before lunch, unless this discussion occupies enough time that it doesn't seem appropriate. So I just wanted to alert people. And we will have a public comment period before we break for lunch.

DR. LEWERS: Thank you. I'll try to be brief. I wanted to come back to a point that I would like you to pay some attention to if you could, Jim, because Bill Curreri and Jack brought this up earlier. That is the, where do you go for a procedure and how severe is the comorbidity, et cetera, of the various areas.

I have just been in discussions as recently as yesterday with a specialty that is very concerned about the payment changes currently happening because of the drop in practice expense. That if they do a procedure in an ambulatory center or a hospital outpatient department, and yet if they can do the same procedure in their office, they'll go to their office. Because their offices are running and their practice expenses are continuing whether they're in an ambulatory center or not.

This specialty, which I'll talk to you about later, is very concerned that procedures are being done in the office that should not be done in the office because of that stimulation, which is the exact point that Bill was trying to bring up earlier. So I think that should be addressed.

The other thing in the paper, a couple things that have hit me. A number of them I'll not bring out now, Gail, because of the time. But we talk a lot about practice expense, and on your charts and in various tables you have practice expense. But have at no place in this paper that I could find talk about the changes that are going to occur and be dramatic in practice expense.

DR. MATHEWS: That is correct.

DR. LEWERS: You need to at least clarify that. I think the point on ambulatory surgical centers is very important because the CONs are changing dramatically, as Woody said, and there are a lot of areas where they're going to explode in the near future.

The other thing that you have not pointed out and, as said here, are technical advances. You talk about cataract, lap chole's. In your paper in one area you imply that it was the payment mechanism that changed the services as far as cataract and where they went, when if you look at the date that you pointed out, that was also the date that major technical advances occurred.

Another area in the charts -- and I only bring this out, it's almost editorial -- where maybe some of the people in the audience could be confused by it. I think the data you're using is '96 because it's probably the last full year that you have available to you.

DR. MATHEWS: That's correct.

DR. LEWERS: You also point out a surgical conversion factor. So you need to clarify, there is only one conversion factor.

DR. MATHEWS: That's correct.

DR. LEWERS: And in your paper you also use that repeatedly about conversion factors by type of service. So I think those areas need to be clarified. There are a number of other areas that I think need to be clarified and I can do that privately with you.

DR. WILENSKY: As always, if you have individual comments, ideas, editorial suggestions, please share them with Jim.

DR. KEMPER: I just wanted to raise a question about the section that's not there on the rehabilitation services and therapy. I'm glad to hear you plan to do that because I think a similar kind of analysis is important. It strikes me as a very difficult analysis and I just wanted to make sure that you were going to include all settings in that, the SNFs, rehab hospitals, and in-home therapy so we get all segments.

DR. MATHEWS: I will not be the person doing that analysis. Stephanie Maxwell on our staff will be, and I'm sure she is planning on --

MS. MAXWELL: Peter, at this point we've included data from the SNFs. In terms of the discussion which was supposed to be oriented more toward outpatient therapy, we were not including the SNF care in the same vein because the therapy services provided to SNF patients and possibly to home health patients would be to those that are maybe more functionally disabled than those that would be getting outpatient therapy.

So we do have some of the therapy services provided to SNF patients that come out of the old Part B payment rules. But this outpatient therapy analysis was oriented toward the BBA payment changes which limit it to the outpatient sites like hospitals, rehabilitation agencies, and CORFs.

We're actually interested in a more detailed analysis of this later that does bring in the therapy across the settings which would include all of the therapy in SNFs and home health because it does obviously raise some of these questions that you probably thinking of.

MR. SHEA: I think this is a pretty thoughtful piece and there's a lot here to chew on. I would particularly congratulate you, Jim, for the way in which you explicitly referenced the beneficiary issues in terms of payment, and I would just encourage you to go further in that direction in future work here. Your point in answering the question about the studies on beneficiary choice is important.

And I couldn't help but think, because we had this discussion with all of the question about what factors are important in terms of where things are done and how things are done, and Ted's point about maybe they even wind up being done in not the optimal setting because of some payment. I couldn't help but think of how far we were conceptually from the idea, which is so much in vogue these days at least in the broader policy discussions, about having people be able to make choices and control this process.

I just think some further conceptual work on what we need to do to push this, whether it's including more in the drafting here or talking about research that maybe hasn't been done but could be done someplace, or should be done. The idea, for instance, of surveying beneficiaries on this. Because I just wouldn't want to -- we may not be able to go much further this year or maybe even next year, but maybe if we started thinking about what research needed to be done we could do something a few years down the road.

DR. MATHEWS: You mentioned pushing this a little further in the conceptual directions. In all candor, something that would help me as an analyst would be for the Commission to chat a bit about a definition of what you actually mean by standardizing Medicare payment across these

settings. I mean, I have a definition in mind. Some of my colleagues have definitions that might differ. But I need to be able to carry out your decisions here, and to the extent that you can talk a bit and tell me a little bit about what you're thinking and where you want this to go, that would be extremely useful from a conceptual standpoint.

The numbers I can do anything with. There's an adage in Washington that if you torture numbers long enough they'll confess to anything, and these numbers have been tortured a lot. So it is the conceptual area that would be useful.

MR. JOHNSON: Just a couple quick observations. First of all, I also would like to congratulate Jim. I think the length of the discussion, while it destroyed the agenda, at least showed the interest of the Commission in the interaction.

Continuing the entertainment analogies though, Jim, I'd say this was not the Titanic. We did hear references to the Field of Dreams from Joe. I'd say this is more like the X-Files, the line, "the truth is out there somewhere." And all these things, of course -- and it may be the economist in all of us -- there has to be a rational explanation for everything. We can't accept chaos theory because underlying that is the knowledge that there really is a reason, we just don't understand it. I think that's where we are; what are the drivers?

If we look back historically, are we where we are today with outpatient because of payor demand by government? Are we here because of technology? Are we here because the clinicians want us to be here in terms of mix of services? Are we here because it's better for the patient? I don't know, but hopefully you'll have all the answers to these questions in two weeks.

And Joe, the comment to you, I think hospitals probably have shifted costs to the outpatient area, and I don't think that we can necessarily assume that that's bad. After all, we're asking them to maintain an entire enterprise. It's like real estate: location, location, location. There's a bell-shaped curve. Some people are doing real well, some are doing average, some are doing bad.

But for example, if you look at a small and rural hospital of 50 beds that's trying to make ends meet with three Medicare patients, a couple of surgeries, an emergency, and a SNF, and some other things going on and still being asked to meet all the different requirements, there are reasons. If we strip all the costs out to somewhere else, centers of excellence, labs done by one company intergalactically, eventually we'll be down to that one patient that we admit that costs $5 million to treat for a three-day stay.

So I don't think we can necessarily just make the assumption because there is some cost shift that overall in the total scheme of things in the mix that that's necessarily bad. I think it really does come back down to what's best for the patient, and again, what's our vision? That's what I heard Jim ask about. Conceptually, where is it that we're driving to? Is it one integrated system where we have a handle on all the costs? Is it a capitated payment? What is it, and is this just a transitional factor?

Those are just my observations.

DR. WILENSKY: Thank you.

Jim, you have lots of work to do before we take this up again April 23rd, but I think it's safe to say that we will not resolve all these issues between now and then, so you'll know what

you can work on for next year.

DR. ROWE: Well done. Thank you.

DR. WILENSKY: Because this has been such a major issue, before Helaine, why don't we have the public comment, because this is an area that we have spent so much time on? And then Helaine will do the BBA schedule.

MS. COYLE: Just three thoughts on this last discussion. One, whether or not the Commission has considered the possibility of developing a set of principles around ambulatory care payment? I heard at least five things around the table. Clearly there's not agreement, but someone offered financial incentives should not direct patients to one particular site. Someone else offered that payments should not vary across sites. Another about equalizing profits, a fourth about services being provided in an optimal setting, and finally this issue of patient choice of settings. All of those potential principles that might help long term in evaluating some of the technical aspects.

Second thought, in terms of one of the potential principles about financial incentives not directing patients whether or not that really leads to a conclusion that payments should not vary across setting. It seems to me the issue is whether costs vary, and then in fact whether those cost differences are legitimate. If they are legitimate and you move to a payment system that does not vary across setting, you will redirect patients to different sites. Just something to keep in mind.

And then third and finally, some consideration -- I don't know if it's further research for poor Jim or whether it's just some discussion in the June report about unintended consequences, and it's a follow-on to Judy's point, a couple of others. We've just come off two weeks meeting with hospitals around the United States. One is some concern that's been expressed about a focus on per-unit costs and not health care system-wide costs. And that is with the proliferation of different sites are we focusing perhaps too narrowly on what's happening on a per-unit basis on not enough perhaps on what's happening system-wide in terms of cost, capacity, et cetera.

Second, just implications for proliferation of new sites for capital investment in hospitals. Obviously something of concern to hospitals, but what that might mean for the longer term standby capacity, charity care, ability to provide those sorts of things.

Thanks.

DR. WILENSKY: Any other public comments?

[No response.]

DR. WILENSKY: Helaine?

MS. FINGOLD: I have one overhead just to give us a little bit of a structure for following through and I'm passing around a chart. It's a little more detailed than the one that's going up on the overhead, for the benefit of the commissioners.

I'm mostly here to get on your case early and have you think that -- you may only be thinking about the June report right now but there are other issues looming out there. And while you're reviewing things for the June report, please pay attention because there are a number of major regulations that are coming out in the next several months that really gives the Commission the opportunity to have some input into the implementation of the BBA. Since the Commission came together last fall that's been one of the centerpieces of our discussions is having an impact

and helping HCFA to implement the BBA.

We have addressed some of these issues, but in large part a lot of them have had to be theoretical because we don't know the specifics on a lot of these programs. These upcoming regulations will address a lot of the specifics, and we have no meetings scheduled during the period of time after they come out before the comments will be due. So what I'm just trying to do is to get you thinking about the issues that are going to be coming up in these regulations and the issues that you want to keep in the back of your mind when thinking about them.

MR. SHEA: Are you suggesting, Helaine, that we need to think about how we would want to participate in this process?

MS. FINGOLD: I'm getting there. I'm going to give you a talk about -- partially I'm going to lay out which regs are coming out and what the topic matters are, and also what our vision was and how we were going to address that, how we were going to review them and then distribute the comments, just so you have an idea of the process and you have a sense of what's out there to come substantively.

We were hoping that would help you even when you're doing the review for June because you may be able to keep things in mind that you're reading for June to know that some of these questions are going to be answered and some of these issues you're going to want to hold on to because you may be able to address them when the regs come out, when we want to comment on the regs.

This is really our opportunity. This is when HCFA is in the production mode. They're open to comments. They're taking public comments. They're developing these programs and this is really the chance we have to have a big impact. Unfortunately, it just doesn't coincide well with our report schedules.

DR. LAVE: Can you tell me, are these BBA dates or are these likely dates?

MS. FINGOLD: They're both. They're approximate dates. The first one says mid-April. It was supposed to be out April 1st, but when I looked at that I realized that April 1st was gone and it's still not out. It's supposedly coming any day now, the solvency standards. Many of them are approximate dates that we've heard on the street or from HCFA. Some of them are required dates. I believe the physician fee schedule is required to come out on the first of May under the statute.

So the dates are all approximate. They may or may not be met, and therefore, the comment dates are approximate. Generally, the comment dates on the regs are 60 days. One of them is 90 days, the physician fee schedule under the BBA they require a 90-day comment period. The last two listed on the chart are reports that were required under the BBA and those two reports are not -- we're not specifically required to comment on them. Excuse me, let me restate that. We are specifically required to comment on them by our mandate in the BBA, but those two we have six months to comment on.

But let me go through them piece by piece because otherwise we might miss some of it. I'm going to give a little more detail on some than others because some you have heard about, some you will hear more about today or tomorrow or in the next two weeks.

The first one we're expecting is, again, the solvency standards for provider-sponsored

organizations under waiver to participate in the Medicare+Choice program. Again, they're expected any day. These regs were created through a negotiated rulemaking process that concluded fairly recently. The things you're going to want to be looking at -- we'll review it, but HCFA has standards, has applied certain net worth requirements and other solvency standards. They're going to have the opportunity -- they're going to be given the discretion to lower those standards under certain circumstances. They're going to be describing the process and we're going to want to take a look at that to see how we feel.

The update to the hospital inpatient PPS is expected to come out around mid-April. This updates the payments under the inpatient PPS system, recalibrates the DRG weights. The biggest issue in this reg that's coming out is the new transfer payment policy for discharges to post-acute care. The Secretary will be designating 10 DRGs for which discharges to post-acute facilities will be subject to a per diem payment rather than the full payment rate per discharge.

We have an idea -- I believe we've seen the possible list of DRGs from which they're choosing. I think there's a short list of about 20. Our first read is that they're all fairly reasonable choices and we can understand them, we are still going to want to evaluate whether we feel some were more appropriate than others. So that is one thing that we will be looking at on that reg.

The next reg to come out -- and I tried to put them in order. I hope they're still there -- is the SNF PPS reg expected to be out by the end of the month, the end of April. Again, a 60-day comment period. Some of the issues that might be problematic are not necessarily regulatory. Some of them come out of the statute. Again, those are still things we can address if we want to. One of the biggest issues is rules for consolidated billing. They're things that used to be able to be billed under Part B, are now going to go under the per diem payment.

The prospective payment rates are based approximately on a '95 base year, the blended -- so it's a four-year transition period, though I think by the fourth year you're 100 percent national rates. One of the other issues they have is the facility-specific portion doesn't account for case mix changes, changes from the base year.

The next reg to come out is, again, the fee schedule reg. It's required to come out May 1st; a 90-day required comment period. The biggest issue in the fee schedule reg is something that's been mentioned and we'll discuss in more detail this afternoon, is the new resource-based practice expense relative values. You're having a presentation right after lunch by Bill Scanlon and Terry Kay to discuss this issue. Pay particular close attention because we also have to comment on the HCFA report on their data and how they calculated these values. So not only are we going to want to comment on the reg, but we do have a statutory requirement to comment on the HCFA report.

Following that which should be the hospital outpatient prospective payment system regulation. Jim mentioned it briefly. It's expected or hoped to be issued in mid-May because the goal is to publish the final rule by October 1 of '98. Again, a 60-day comment period. Many significant issues. Setting the aggregate expenditure target, the unit of payment, relative weights of services, payment adjustments on geographic, teaching adjustments, DSH, outlier policies. There's a long list and I'm sure Jim is available if you want to discuss any of those. I'll pass you off to him.

The Commission may want to comment on how the proposed PPS system fits into broader ambulatory care venue relationships. Again, the relationships amongst and between settings, the degree to which outpatient PPS concepts could be applied to other ambulatory settings, et cetera.

DR. ROWE: Can I ask a question? When you say that the BBA requires that we comment on something, does that mean that we need to comment within this 60-day period, or does it mean that we have to address it in our report like the June report?

MS. FINGOLD: We could probably do that within in the scope of our report if we want to. When I say we are required to comment on the reports, the BBA in our mandate, the MedPAC mandates says that MedPAC is to issue comments. When HCFA or the Secretary of HHS is required to submit a report to Congress, MedPAC is supposed to provide comments to Congress also on HCFA's reports. We have a six-month period from when that report is transmitted to Congress to then submit our comments on the report.

DR. ROWE: I see. I was confusing that with the 30 or 60-day comment period.

MS. FINGOLD: I wanted to put them both on the chart because I wanted people to have in mind that there are these regulatory burdens, but we also have these other things out there that we need to be addressing. The regulatory burdens and the comments on the regs are more, this is our opportunity to do that, this is our opportunity to have some input at a definitive time.

The reports are statutorily mandated, we have to comment on them. Should the commissioners choose to do that in the context of the June report, we could probably do that. The timing may not work well; I'm not sure. And Kevin may want to address that -- Kevin and Murray, I'm not quite sure how they're going to want to handle that.

One of the biggest regs that you've heard a lot about and will hear additional information about at the next meeting, not this time, is the Medicare+Choice mega-reg.

[Laughter.]

MS. FINGOLD: It's scheduled to be out -- let's hope it's not the Titanic. The Medicare+Choice reg is due out June 1st. It is extremely broad-based, dealing with all aspects, many aspects of the Medicare+Choice program, beneficiary issues, quality issues, appeals and grievances, standards for participation, in large part provider network issues. Sarah Thomas will be talking about this at the next meeting in a lot of detail and you should be receiving those materials in your packages soon, I believe.

DR. WILENSKY: Helaine, was this a negotiated -- are any of the others, other than the PSO, negotiated?

MS. FINGOLD: No, the PSO is the only negotiated rule. The Medicare+Choice rule is being developed by HCFA now, but I don't think there was any standardized input the way the negotiated rule was.

DR. WILENSKY: Was that in statute that that was to be negotiated?

MS. FINGOLD: The PSO solvency standards were required under the statute. It required a negotiated rulemaking process.

DR. WILENSKY: In the other areas is it an option of HCFA to use negotiated rulemaking at their discretion, do you know, in general?

MS. FINGOLD: I do not know specifically. I think it's usually required by Congress, but

I can check that.

DR. WILENSKY: No, I understand sometimes it's required by Congress.

MS. FINGOLD: But do they have the option? I can check that. Some of it depends on the nature the rule. I mean, there are so many aspects of the Medicare+Choice rule I think there's just too much. I think Congress felt that the PSO solvency standards, there was enough of a broad realm of disagreement, shall we say, that I think they felt like if they could get everybody in the same room and talk through it and it gave everybody a stake in the matter. I think it was seen as a particularly good area to work in that manner.

DR. WILENSKY: I just got a head nod that in fact it is at their discretion, because I think in the clinical lab area they are doing a negotiated rulemaking.

MS. FINGOLD: Yes, I believe that's true.

VOICE: But that was in the law.

DR. WILENSKY: Thank you.

MS. FINGOLD: I did mention the report on the practice expense. It was issued, I believe the first of March. Comments for us, we have six months to comment on the report. September 1st would be our due date to go to Congress.

And lastly, there's the report on DSH hospitals. It's due in August of this year. Our comments would therefore be due in February of next year, so that one gives us a little bit more space. HCFA, in that report is required to recommend a formula for distributing DSH payments. There are a few requirements to that report. This formula is supposed to apply to all hospitals. It has to be based at least on the variables in the present law, and it has to discuss data collection needed to implement their formula.

Our understanding is that some of MedPAC's recommendations on distribution of payments should be included in that report, so we will want to watch that closely.

That's it. Essentially, we just want --

MR. SHEA: On the DSH, just so I'm clear about these dates. The report on the proposed reg is six months for this, unlike the --

MS. FINGOLD: Let me clarify.

MR. SHEA: I'm getting confused between what we're required to do in that six months and the opportunity, as you referred to it, to get in the mix when things really get done.

MS. FINGOLD: The top six items on the chart are all regulations. They're all regulations and the date of issuance is on the left, and we have generally 60 days, and in one case a 90-day period --

MR. SHEA: Everybody has.

MS. FINGOLD: Everybody in the public has a comment period. And that is a good opportunity for us to take advantage in commenting.

MR. SHEA: And then the last two are not regs, they're reports.

MS. FINGOLD: The bottom two are reports which I added in because I didn't want that to fall out of the scope of our responsibilities when people are saying, okay, we have these regs to look at. We also have to address these reports. Those are under our mandate.

MR. SHEA: But we're not mandated to comment on the regs.

MS. FINGOLD: We're not mandated to comment on the regs, but it is just really the key opportunity.

MR. SHEA: I understand.

MS. FINGOLD: And I think that was the whole idea is we wanted to impress upon you that you need to keep all this in the back of your head while you're doing everything else the next few days and few weeks.

DR. LEWERS: But the mandated comments should be on the final report. So we can comment on the regs, the proposed in that two, three-month period, but our mandated should really be on the final regs I would think.

DR. WILENSKY: And in fact, again the mandates that exist are on HCFA or departmental reports. That's what we have a mandate for. The regs, to the extent they're on issues where we have views and/or recommendations, it obviously makes sense to have some response to the regs. And to the extent we think that the affected community would be interested in our specific comments we have discussed earlier, and the practice expense is a good example, that not only would we make a comment but that we would at least think about making that reasonably public so that the physician community, or whatever, the beneficiary community, could know what it was we were commenting to HCFA.

MS. FINGOLD: I think we've discussed putting it on the web site once we issue the comments to HCFA.

DR. LEWERS: On a follow-up to that. Since these dates don't correspond frequently with, or at all with our meetings, is that we're not required to have a meeting. We can determine our comments and publish them and put them out without having to have a meeting and public hearing?

DR. WILENSKY: Right.

MS. FINGOLD: Right, we're expecting to --

DR. ROSS: I was just going to say, we'll be discussing some of this in June at the retreat.

MS. FINGOLD: Right, to the extent that we can get something pulled together for the retreat, depending on when the actual reg will be submitted, we can give you materials and maybe we will have a few minutes to discuss. Our expectation is that the staff involved will review the regulations and/or reports issued, summarize the main points, and draft proposed comments. Those will be distributed for comment to the commissioners, who will then review the materials and give staff comments so we can revise it.

But again, unfortunately because of the scheduling, we don't have the benefit of a meeting to get together everybody and discuss and review all in one process.

MR. SHEA: Once you've done this process, do you expect that we would get these as they became available, the staff analysis and suggestions? Or would we do it in blocks of time, or is that --

MS. FINGOLD: We'll probably do it as it comes. Because we can't guarantee when they come out is one of the problems.

MR. SHEA: So when they come out, we can expect to receive sometime thereafter?

MS. FINGOLD: Sometime. Hopefully sooner rather than later. But it depends on the

timing.

DR. WILENSKY: Again, we can take some guidance from what commissioners would like to do. My presumption is that to the extent we have taken a position and the reg comes out, we ought to at least comment within the framework of the position that we've taken. To the extent that we can amplify that by having the staff look at specific operational issues, that's also appropriate.

If it's going to be going beyond where we have already established recommendations, then of course, we would not do that without making sure that that was an area that the commissioners were comfortable with. But it is really combining the technical advice which experts on MedPAC can and should offer, and making use of the fact that our assessment is of interest to various affected parties.

But we will, obviously, be careful not to have comments put the Commission in a position that it has not otherwise taken previously or does not explicitly take. I mean, if that is agreeable with everyone.

Any other comments that people have? I think one of the biggest issues that we'll have to monitor -- and it becomes obvious looking at this list. Some of us have a little skepticism about when all these dates are actually going to occur.

MS. FINGOLD: A lot of them are really on track. There's a few of them that are actually, I believe, sitting in OMB, which may or may not be a good sign. That may not be a good sign in and of itself, but I believe that most of them are on track. So that is good. I haven't heard that any of them are really significantly delayed.

DR. WILENSKY: If there are any significant changes, we will let commissioners know as we hear about it.

Any other comments?

We are going to adjourn until we reconvene for our 1:45 session.

[Whereupon, at 12:13 p.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day.]

AFTERNOON SESSION [1:50 p.m.]

DR. WILENSKY: I know we have both of our guests here. Kevin, are you going to do the introductions? Terry, Bill, do you want to come join us?

DR. HAYES: We're happy to have with us this afternoon two gentlemen who have done a lot of work on the issue of physician practice expense. They've been kind enough to come to the meeting and are prepared to present reports that they've issued recently and to respond to your questions about those reports.

We have first, Bill Scanlon, who you all know. We also have Terry Kay, who is the director of the division of practitioner and ambulatory care in HCFA, the office that is putting together the practice expense proposed rule which will come out next month.

We thought that this session would give you an opportunity to learn more about practice expense and generally get ready to work on comments on that proposed rule. So I'll turn things over first to Bill.

MR. SCANLON: Thanks very much, Kevin. It's a pleasure to be here and talk about working a lot on practice expense. I feel like a neophyte relative to some of you that are on this commission who I think have lived it for quite a long time period.

But as you probably are very well aware, GAO was asked or mandated in the Balanced Budget Act to look at HCFA's proposed rule for practice expense that was published last June and to report back to the committees of jurisdiction for Medicare within six months. We issued a report at the end of February and presented testimony on that. I don't know if you all have a copy of that report and had a chance to see it. What I'd like to give you is a short summary of it today and then I'd be happy to answer any questions that you might have.

In doing this work I think that we came away feeling very strongly about how significant an undertaking it is to try and set practice expense relative values, and in some respects how frustrating a task it is. Perhaps even more frustrating than dealing with the work values, because while the work values involved a number of areas of subjectivity, practice expense with talking about different types of personnel, different types of supplies, space, et cetera.

One would think that these things can be measured and therefore it's a doable task. It certainly is a doable task except when you multiply it by the thousands of procedures that you're trying to estimate relative values for, makes it a much more complicated and difficult task.

We think that HCFA has made considerable progress in managing this very difficult task because in some respects there is no one approach. All the approaches that we reviewed seemed to involve some combination of the collection of data or measurements and a set of assumptions. Assumptions that kind of glue the data together in order to create the values.

In that process there are going to be diminishing returns to collecting more direct information and relying less upon assumptions, and that you need to strike a balance between the additional information that you collect and the strength and breadth of the assumptions that you're using. And we do believe that HCFA has struck a reasonable balance.

In terms of collecting direct information, it seems that you have two choices, either trying to do surveys or trying to actually go out and do direct measurements on-site. HCFA in using the CPEP panels that you're familiar with, these panels of physicians that were brought together to

provide the core estimates, in some respects is operating like a survey involving informed observers to make the original set of estimates, in some respects more powerful than any survey of the same number of responses ever would have been since these were informed observers and prepared observers.

The alternative of doing a widespread practice survey, we agree with HCFA that that would not have been a practical approach given the difficulty of getting a significant response rate for a survey that was inevitably going to involve so much detail on the part of the practices. It would be an overwhelming thing and the practice personnel would naturally resist completing such a survey.

Direct measurement of a significant number of practices in order to give you a solid enough base of measures also seems impractical just because of the cost and the time that is involved.

In using these data that came from the expert panels, HCFA did go through a series of adjustments, in part to convert the different panels estimates to a common scale, to eliminate expenses that had been reimbursed to hospitals or reimbursed as part of the physician work component, to reduce potentially excessive expenditure estimates, and to try and ensure that there was some consistency between the estimates that they generated and aggregate survey data on practice expenses.

We generally agree with the intent of these adjustments. However, in our report we also note that we think that there are potential methodological weaknesses in some and that others may lack some sufficient supporting information to justify those adjustments.

The real question is, how serious are those kinds of concerns that we raise in the report? One of the things that we feel strongly is that we're not able to answer that question at this point because there hasn't been the kind of sensitivity analysis that we would like to see in terms of understanding what it is that generated the particular practice expense relative values, and in particular what contributes to the difference between the proposed practice expense relative value and the current charge-based or fee-based relative values.

Having that kind of information, understanding for which procedures the changes are the greatest and what is the cause of those changes would be valuable information in understanding how one rates or attaches priorities to our concerns, and also where one should invest additional resources in terms of trying to refine the fee schedule.

We were also asked in the Congressional mandate to look at the question of access to services by Medicare beneficiaries under the revised fee schedule. We actually share the concern that this commission has, that this is one additional change to physician fees on top of a number of other changes that have occurred both over time and with the Balanced Budget Act and that it's really the cumulative effect of all of those changes that is going to be the most important determinant of access.

While today we believe that access is quite good for Medicare beneficiaries there may be issues in the future. However, it's not sufficient to look at Medicare fees alone. It's very important to look at Medicare fees relative to other fees. We've heard reports that Medicare is actually one of the best payers in certain markets, despite the fact that there have been changes,

reductions in the fees that Medicare is paying in those markets.

As the other purchasers are more aggressive about trying to control fees, we need to monitor how well Medicare fees and how well access fares in that kind of environment.

We've been asked to look at HCFA's May rule that will be coming out in a similar way to what we did before. Again we hope to be able to look at what it is that drives the changes in fees that would occur as a result of introducing the resource-based practice expense relative values, and then be able to comment from that context of understanding better the causes of the changes.

Thanks very much. I'd be happy to answer any questions you have after Terry is done.

DR. WILENSKY: Bill, thank you.

Terry, good to see you again.

MR. KAY: It's good to be here. My comments too will be reasonably short. I'd like to provide a status report of what we're doing and then we would have time for comments and questions.

As those of you that are familiar with the regulatory process would understand, right now we're in the process of developing the proposed rule so many of the kinds of questions that you have I unfortunately won't be able to be very specific. I certainly will try to be responsive but there are some restraints because of the regulatory process and the clearance process.

The Balanced Budget Act requires we develop a new proposed rule on practice expense by May 1st. We have found this to be a very challenging task. As outlined by Bill, for the 7,000 services that Medicare pays for physician services, this represents about 41 percent of total spending for physicians; roughly about $20 billion. So for each service, in developing a practice expense value we've been looking at the staff and equipment, supplies, and indirect expenses that are typically used to provide each one of these services. So it has been a challenging task.

Last June, 1997, we developed our initial proposed rule. I'd like to describe it that Congress liked it so much they asked us to do another.

[Laughter.]

MR. KAY: The Balanced Budget Act required that we do a new proposal. The new proposal will have a 90-day comment period. It's to be published on May 1st and we're doing everything possible that we can to make that date. There will be a four-year transition. We've been required to consult with physician groups. We're required to develop a refinement process for that four-year period.

So in developing this new proposed rule we have been actively consulting with physician groups. Some of the examples, last fall in October and then again in December we referred to as refinement panels to review our initial data that we had used previously, the data that we collected from Abt Associates looking at direct expenses.

The December panel was a multi-specialty panel where we were trying to refine some of the high volume codes across almost all the major specialties. As I indicated it's been a challenge. Frankly, our December panels did not work as well as we had hoped. We were not able to achieve agreement on any of the changes in any of the numbers in the December meetings. But many of the participants did indicate that they felt the methodology had some promise. We continue to try to refine that process.

We also in November, we had a large multi-specialty meeting to discuss indirect expenses in our allocation formulas and we invited five or six, frankly some of our major critics to come and give us some suggestions on some alternatives, in addition to some others who supported what we had originally done. Just to have an open forum to make sure we had all the suggestions out.

Also last October we published in the Federal Register an advance notice. It's something we don't typically do, but in this case we published about the equivalent of a pre-proposed rule announcing that we were developing this proposed rule and asked for studies or information that we needed to develop these new values.

Since, over the last couple months we've then been reviewing all the comments, reviewing all the input and meeting with groups whenever possible to develop this new rule. I would just kind of summarize. We've certainly received all kinds of suggestions, but as far as a methodology I've described this in a couple other public meetings and I would do the same thing here.

The way the methodology, in looking at the kinds of comments we've gotten, it seems like there's certainly all kinds of variations and sub-options that one can develop but some of the major approaches that we've heard of from commentors is the original methodology that we used has been described as kind of a bottom-up approach. By that I mean that for each physician service, our contractor, Abt Associates helped us look at each individual physician service and build up what the relative value would be.

In other words, we looked at for each service, kind of spell out what the staff are that do the service, what equipment is needed to do the service, what supplies are needed to do the service, and then add on indirect expense amount. So it's kind of been described as a bottom-up approach.

Another example that's a different methodology, we received comments, for example, from the Practice Cost Coalition working with an accounting firm, Coopers & Lybrand. They've developed a process that they describe as kind of a top-down approach. By that it's meant that you identify aggregate practice costs and then allocate those down to individual codes.

So we've been actively looking at those two general approaches and some others. And as I indicated, there's lot of sub-options that one can develop.

I would just note the data sources that are available to develop these practice expense values, after extensive search, in addition to original Abt data from our contractor the other major sources of practice expense data that we've found are available is the American Medical Association's socioeconomic monitoring system, an annual survey of physician practices that they've been doing for some time.

The Medical Group Management Association has a survey of group practices and in that they collect some cost data. It doesn't have the same -- the AMA's data is apparently a scientific random sample. The Medical Group Management Association doesn't have the same sampling characteristics but we've been looking at it in a way to supplement our other data sources.

The American College of Surgeons had contracted to collect practice expense data from a sample of surgeons. I would just note that the samples for the surgical specialties that they've collected is fairly small but in the aggregate it provides some overall practice expense data for

surgeons.

In addition, as I indicated, we had the notice in the Federal Register last October and in that we had asked for specific comments, for example, on equipment and equipment usage. And we did receive, in some cases, information that we're looking at.

I would just also note the kind of wide-ranging types of comments that we've received, in many cases specialties indicated to us that we should be relooking at our indirect expense allocation and develop some type of a specialty-specific indirect cost allocation. Then a number of others had suggested that we look at administrative costs as an indirect expense instead of a direct expense like we had done in the original proposal.

So in any case, that kind of gives a range of what we've been looking at and what we've been doing. As I indicated, we're doing everything we can to meet the May 1st deadline. So that would be a good time to check the Federal Register. We're hopeful of making it. It would be a 90-day comment period and our schedule would be, we would have a final on October 31st to have the new fee schedule start the transition in January 1999.

So that's kind of a status report of what we've been working on over the last nine months or so.

DR. WILENSKY: Thank you.

Let me open it up now for questions.

DR. NEWHOUSE: Thank you both for coming here. Let me ask you a question that's future oriented rather than what's gone on until now which is kind of at two levels. One is what -- this is more I guess for Terry -- is what is the -- both of these are about updating whatever you do. Is there some body analogous to the RUCs that will be perfecting what you do?

And then secondly and more generally, suppose that in fact access problems crop up in parts of the country, say for talking purposes, like 20 to 40 percent of the country, what are your thoughts about what to do next? They crop up for certain procedures or certain specialties, which seems to me if they crop up that's how they're likely to crop up.

MR. KAY: We're required in the Balanced Budget Act to define a refinement process and we've certainly been looking at it as actively as we can. On the other hand, the precise refinement methodology is somewhat dependent on what the actual proposal is. And in discussing this issue with a variety of specialties we've had the suggestion that what we should consider is maybe an outline of what the refinement process would be so that we don't close off potential comments and suggestions that we could receive during the comment period.

So it will be a fine balance between meeting the requirements of the Balanced Budget Act and staying a little bit flexible here.

I would just say that the RUC process has been getting some examination. I was at the last RUC meeting and they set up a subcommittee to take a look at this issue and develop some proposals.

DR. WILENSKY: Terry, why don't you describe just -- since some of the predecessor commissioners have been much more focused on what goes on in the hospital world, and Joe, having had his time on PPRC may bring a little more knowledge. If you could just spend a minute or two describing the RUC process, what it is and how it works, so people can put in context

your comments?

MR. KAY: The RUC is the relative value update committee, and it's been supported by the American Medical Association. But I think the way they organize it it's somewhat independent of the AMA. There's representatives on the RUC that represent most, every major specialty. In some cases there's a rotation. There's about 28, 25 members on the RUC. They get together just about every three or four months and they review, based on requests from HCFA they review relative values for work.

It's something that started shortly after the fee schedule went into effect in 1992. The process has evolved over the years, that I think most everyone associated with it feels that it has worked out reasonably well. It's been helpful to HCFA. Again, any recommendations the RUC makes, they're advisory in a sense that HCFA ultimately decides what relative values to establish or what relative values to change. But they're certainly informed comments that we take seriously.

So it provides a nice forum for a multi-specialty panel to take a look at recommendations. And they go in to quite some detail for the codes before voting on whether to recommend a change to a value. They consider survey data. They look at how long a procedure takes, the work relative to other services on the fee schedule.

So the suggestion has been that maybe something like this could work for the practice expense portion of the fee schedule. Exactly how you would do that, how the group would be formed, who would be on it, has not been developed. As I said, the RUC had charged a subcommittee to develop some proposals and they're going to look at it in the next RUC meeting which is the end of the month. So we'll know a little more.

Some of the thoughts have been that maybe that kind of a process could work, but that maybe it needs to have a different formulation. That maybe it needs, rather than just all physicians, maybe it needs a lot more maybe some practice managers, maybe some representatives from managed care to kind of supplement the expertise on that panel.

So the RUC or something like that could potentially be considered, or some kind of an independent process. There would be a lot of desirable -- have a lot of reasons why we might want to have an independent group also. So it's still in development.

DR. NEWHOUSE: How about the second part of it? Suppose some non-trivial access issues develop but they're still somewhat scattered? In response I would want to distinguish between things that might require a change in statute and things that wouldn't.

MR. KAY: HCFA would be continuing to look at access. To the extent we receive information about access problems that, at a minimum, would be a flag that perhaps the values established are not correct, and that could be a flag to take a closer look at those values within the current statute.

MR. SCANLON: I think, Joe, you've raised or you've opened the door to a very interesting question which is really an issue of how these fees should relate to market realities. There's a question if you do identify -- and I agree with you that we would probably identify access problems in isolated areas initially and with respect to certain services. If you then try to make those fees sensitive to those market conditions, should you also go in the other direction

which is to determine whether Medicare is overpaying in certain markets? And how do you introduce a process over time that adjusts for the shifting market conditions across the country?

It seems like a worthy task for this commission to consider.

[Laughter.]

DR. WILENSKY: Woody, if this isn't a follow-on let me do Bill Curreri, Hugh, and then you.

DR. MYERS: It's is a follow-on to the RUC question. Just to make sure that I understand. There's nothing in statute or regulation that creates the RUC. It's a voluntary group that gives advice to HCFA. I take it that you tend to take that advice?

MR. KAY: Yes, to both. In other words, there's nothing in statute about --

DR. MYERS: And if there wasn't a RUC, you would in some respects have to invent one. Is that also a fair statement?

MR. KAY: I think that's fair, yes.

DR. MYERS: So what you're suggesting is that given what this new mandate is that you want to have that in the same route that you have it now; i.e., informally? Or would you want it in regulation or statute? That's the piece I'm not catching.

MR. KAY: I think based on the experience of the RUC it's worked out -- I'm not quite sure even if we had it in statute or did not that it really would have affected the process. Is there a specific concern about that that I could --

DR. MYERS: No, I'm just trying to understand what you're asking for.

MR. KAY: I'm just saying that we know that the RUC is developing some proposals and we're open to taking a look at them. As far as whether we would find any of the proposals acceptable or not, at this time I don't know.

DR. WILENSKY: Why would HCFA want to have this in statute?

DR. MYERS: I didn't want to exactly put it that way, but you've got informal advice coming in now that you're using and you're using it well. I suspect you're happy with what you're getting. But then you mentioned before when you opened that maybe we need to do this in a different way.

MR. KAY: I'm sorry, let me clarify that. I was referring to the Balanced Budget Act that requires us to develop a refinement process. So establishing some kind of a process of that would meet the requirements of the BBA, of the statute. I'm not saying we want any additional requirements in statute. I think we've gotten the mandate to develop a refinement process and I think that's sufficient.

DR. WILENSKY: I was going to be worried if you said you did.

DR. CURRERI: I actually have three questions that I could probably address to either one of you. The first one is, in contrast with the work values that were developed where a same or similar process were used where expert panels were put together and work values were done, and even though there was linking that had to be done and a number of other things, there didn't seem to be such drastic changes between what the original panels came up with and what ultimately came out. And one of the criticisms I'm hearing from the participants of the original CPEP panels is that through the validation projects and all these adjustments that were made,

sometimes administrative costs were doubled in certain procedures and in other cases they were reduced by two-thirds or more. There's just a real terrific misunderstanding of what you all did from the original CPEP panels.

So I'd like you to comment on that. And I think that I'm trying to suggest that there's going to have to be real education if you're going to want to have a large majority of physicians to accept this data.

The second thing, and you may want to comment on this, is that I think that, just like with the work values it's not realistic to expect you're going to have everything just exactly right, and I think one of the things that was very valuable in selling the work values was a specific outline of a potential refinement process with the intervals that they were going to be looked at. Who is going to do it I don't think is so important, but I do think that in your May 1st I would not just be so general to put an outline out there that's so flexible. I think people have to have some security that there's going to be a way to fix things that are wrong.

I would urge you, even if you have to change it after you get comments, to have some specific outline of the refinement process.

Then thirdly, I see a lot of enthusiasm in fairness on the part of physicians to look at specialty-specific indirect costing. There are a variety of good arguments for this. I know there are a variety of good arguments for the approach you took, too. I know that you've had access to the AMA specialty-specific costs and I wondered whether you at this time think that there's any likelihood that you're going to readjust your indirect cost estimates on a specialty-specific basis or not.

Then lastly, I have the same concerns that Joe put up. I predict, and I may be wrong but I predict and I feel very strongly that there are going to be access problems, not because of practice expenses, per se, but as Bill Scanlon said, because of going to a single conversion value and reductions in payments to some specialties by as much as almost 50 percent and increases in others by 20, 30 percent over a relatively short period of time, shorter even than the work values were introduced.

I think I'd like to know that HCFA has some plan to deal with this, and I haven't heard any yet. So I'd like you to comment on that.

DR. WILENSKY: That's a lot of issues. Terry?

MR. KAY: Hopefully I got them all. The first issue about, what exactly did we do in developing the original practice expense values. Clearly we need to figure out a better way to communicate what we did. So hopefully this next go-around will be clear. I guess the point would be that if you look at what was originally done in the Harvard values with work values, work is a different issue, as explained earlier.

But in that process Harvard did surveys and panels establishing work values, and then they did adjustments and linking to standardize them, normalize them across all the different panels. So in that respect the concept was similar to what Abt had done, that there were independent panels, a series of 17 panels that collected data. In some cases there was overlapping codes, so that these overlapping codes that were measured in each panel, they were used to do an adjustment and normalization of all the data across the board.

There's been a lot of concerns about exactly what we did and the methodology, and we received plenty of comments from the GAO and the GAO staff about that, and we've been looking at that. But I guess I would just say simply that if you just looked at the raw data that was collected by the panels, and like I say, I hope we can do a better job explaining this in the future.

But one example -- and I hate to pick on any particular specialty, but to give an example I have to pick out one and so radiology is the winner. If you take at the raw data from the panels and the data we collected on equipment and equipment usage, and if you just accumulated all of those values and looked at billing patterns in Medicare, and you just literally accumulated those dollars you would end up with well over $1 billion worth of expenses for equipment for radiologists.

But if you said, is $1 billion or more, is that about right or does that sound like it's too much or too little? We then looked at other data sources to see, what data do we have that can indicate how much radiologists are spending on equipment. So when we looked at the AMA data -- and I'm just doing this from memory so my numbers could be a little off, but just to illustrate. If you look at the AMA data it might suggest that $300 million is about the right amount. That the radiologists reported equipment expenditures of $300 million.

So if you look at our raw Abt data it says $1 billion. You look at the AMA data you say that it's $300 million. And the way we've described it is, we think our panels, the Abt panels did a reasonably good job of looking at relatives from code to code within a family of codes, but that we need some other mechanism to scale that data down to something that more closely resembles what the real costs are that are being spent.

So in that case, I hope that helps. It's just we can't use the data in its raw form, that we need some way to normalize the data across our different panels.

MR. SCANLON: We're very sympathetic to the views that you express. One of the issues of doing some sensitivity analysis to know how we got from the original CPEP estimates to the final proposed value, and then there's a whole series of steps. So understanding what each of those contributes, and one of the difficulties is that they often are interactive so disentangling things is not easy. And the idea of bringing in other information and specialty-specific indirect ratios is another bit of information that one may or may not need depending on the quality of other information that one has.

I have to say, Terry, that in your example I'm not sure how that information about the AMA's estimate of radiologists' equipment expenses would get incorporated into this process. I think that's the kind of thing that we would encourage HCFA to consider is that when you have other information like that, is there a way to insert it in the process to refine the values. That's I think something that we will look forward to in May.

MR. KAY: The other issues you raised about the refinement intervals, access problems, and specialty specific they all fall in the category of, I wish I could be more specific. But very soon there will be a proposal that will be public and then fortunately we'll be able to get into the details.

I would just say that on specialty-specific indirect costs, for example, that's an issue that

we've taken seriously and we've been giving that a fresh look. And as I indicated, a few more weeks I'll be able to describe better how we came out on those issues.

DR. LONG: This is perhaps somewhat related to that last point and it's a question being asked by a commissioner who doesn't come from having spent time on PPRC.

This morning this commission spent quite a bit of time beginning to grapple with the issue of institutional payment for ambulatory care in a variety of settings. One of the observations which came up is that the indirect costs in ambulatory surgical centers may be very different than the indirect costs in hospitals, et cetera, in thinking about what happens as you perhaps move to a single payment amount for doing the same procedure in different settings. A number of philosophical alternatives were presented as to whether you want cost-adjusted payment or single payment, and what policy objectives you're trying to achieve and the way in which the site of service may alter.

It occurs to me that there's really an analog here, or at least appears to me as a naive observer to be an analog, when we start talking about different specialties with different indirect costs in aggregate and different mixes of procedures that may lead to different allocations. Yet where we're coming out is a single payment amount in a given geographic region regardless of whether specialty A performs a particular CPT code or specialty B performs it.

I wonder if you could say something about perhaps the philosophical approach to this notion. Is the intent to ultimately have each procedure performed by only a single specialty, or do you think that that doesn't matter, or where are we going with this whole notion as we recognize the cost may be different but we move toward a single payment amount? Because that may inform, to some degree, where we come down on the institutional payment for services provided in different cost settings.

MR. KAY: I guess I would have to say that we've found implementation of this statutory requirement extremely challenging. The more philosophical questions we recognize as extremely important and we're looking at them, but right now, basically under the physician fee schedule even if we recognize specialty-specific indirects we would still feel that we would have to do that in a way that in the end we would pay the same amount regardless of which specialty does it. There's a statutory requirement that the fee schedule, that there's no specialty differential.

So I feel very safe in saying, although there's no proposal on the street I think we'd all be shocked if we came out with a proposal that in the end for a given code had a different amount depending on which specialty that does the service.

DR. WILENSKY: You were not here for this morning's discussion, but in fact that issue is inherent in the relative value scale, that there is no differentiation according to the specialty that does it even were there to be different costs involved, at least the philosophical basis that underlay the relative value scale to date. So the issue that we were raising looking at ASCs versus outpatients versus physician's offices as a principle has at least been answered to date in the relative values.

MR. KAY: Right, and I was just going to add the philosophical part of it that we haven't gotten too far with is the issue you're raising about the facility payments. It's an issue that we know we'll need to deal with. Once there's a national fee schedule out there for the same service

in different settings, I think it will be quite obvious that there will be differences and then it will raise questions about why are there those differences. I know the Commission work plan has indicated that you'd be looking at that, and frankly, we look forward to hearing what you have to say and your suggestions on those issues.

DR. ROWE: Can I ask a question about this? Let me see if I got this straight. We pay the same amount regardless of who does it for a given service if the service is exactly the same service. For instance, if we have a general practitioner, a board-certified internist, and a board-certified cardiologist all read an electrocardiogram. That's the same payment because they're all doing the same service, they're reading an electrocardiogram; is that right?

DR. WILENSKY: The work expense would have been the same. There is a component for malpractice that could come in. But the answer fundamentally, the philosophical underpinnings of the relative value scale would say, yes.

DR. ROWE: Let me ask you, Terry, if you had an electrocardiogram and we could have one of those three doctors read it, would you care which one read it?

MR. KAY: Medicare would pay the same amount for each service.

[Laughter.]

DR. ROWE: I think we've identified the problem.

DR. WILENSKY: Jack, you're only about nine years too late. This is part of the November 22nd, 1989 decisions about the relative value scale.

DR. ROWE: But I think that --

DR. WILENSKY: Government pricing doesn't make a differentiation for quality issues.

DR. ROWE: I understand that, Gail. But what my objection or point was, I think I recognize that, and it's about the average number of years that I'm late on most things. But what I was objecting to was the suggestion you made that since that decision was made nine years ago, we've already made that decision and therefore we might extend that to all these other decisions that we're currently considering. And I think that we don't want to necessarily do that, particularly if we think maybe that wasn't a perfect decision.

DR. WILENSKY: You literally would have to go back to change the relative value scale. This is fundamental to the principle of the relative value scale. I happen to have had this irony of living through being HCFA administrator in implementing the relative value scale, and then moving to PPRC where I could comment on it, and moving to MedPAC where I could further comment on it.

I do not want to be in the position of defending this, but it is the basic structure that underlies the relative value scale, and to change this point literally goes to the whole heart of the relative value scale. So I am more than happy to have this as an issue but you take the whole structure down.

DR. ROWE: I understand. Thank you.

DR. LAVE: No, not necessarily.

DR. WILENSKY: As it now stands you do.

DR. LAVE: I'm just saying, one of the things that I understood in some of the Canadian payment systems that in fact you have a slightly different payment rate if the service is provided by

somebody who in fact is a specialist in that area. So you could have a general payment rate and then up it a little bit if it's a cardiologist. And they did the same thing, if it was a general -- I mean, this was some time ago, but if you had something that a generalist should do, then the generalist would get the up, and a cardiologist would get the down.

So it is possible -- you can think of ways that would not totally throw a system down that would say that you might get a little quality oomph and you pay for the quality oomph if it's tied to a specialist who's specifically tied to do that. So I think that it is clearly not something that we have philosophically done, but I don't think it would tear apart a system to have a specialty add-on for the specific specialty. Whether you want to do it I'm not saying, but I would rather have my cardiology thing read by a cardiologist personally.

DR. LONG: But it is true, is it not --

DR. ROWE: You get the honesty award for the day.

DR. LONG: -- that the practice expense component is now some kind of a weighted average of the indirect cost of the various specialties that may provide that service?

DR. WILENSKY: That is in general what happened during the work value, the first component. It is looking at the various individuals who do actually do this and trying to make the linkages so that you have the same relative position.

DR. LONG: Is that also true of the practice expense?

MR. KAY: Correct. The current charge-based practice expense and malpractice relative values are a weight average of the specialties that do each service.

DR. LONG: So we've got winners and losers by specialty getting the same amount of money?

MR. KAY: Correct.

DR. LEWERS: Just a comment for Jack. Jack, I was on the RUC at the time that that subject came forth and the value of the work is the same, and that's where the big element came in, and to have 27 specialties which sat and discussed that, it was a most interesting, frank discussion.

You may not be able to answer my question, but in the earlier proposal you gave options on a couple of issues for comment during the comment period. Do we anticipate that at this time or do we think with the refinements that we've had through this process we'll be more direct? Or that may not be something you can answer publicly at this point.

MR. KAY: Right, I can't be very specific. But even if we have more than one option, we would still say, this is the option we're proposing. So the additional option or options that might be listed would be there for informational purposes to help generate comments.

DR. LEWERS: There would be the one that you would recommend and then the others that would be available for comment?

MR. KAY: Correct.

DR. KEMPER: The GAO report recommends monitoring access and pays some attention to that. And you indicated that one of the comments that you got was, it's not just access but it's also quality and appropriateness that could be affected. Have you thought through what plans you have for monitoring the effect on access and perhaps some other dimensions of quality? I

guess HCFA has some responsibility of monitoring access, GAO does, and the Commission does.

MR. SCANLON: No, we don't have a specific plan at this point. One of the things that we have to rely on generally is other's information. So HCFA's role in the primary collection of that information is going to be critical and we would expect to be utilizers of that.

The issue is something that I think exists today even before we introduce the practice expense ratios or values, and the Commission has been addressing that. In fact recently we issued a report which relied on the Commission's information which they have been generating over the years on the access question. So we will be vigilant but we don't have a specific plan at this point.

DR. KEMPER: How about HCFA's plan for the access monitoring?

MR. KAY: There's a group in the HCFA research office that has been doing access reports for some time and they would be continuing those. I guess we would be reviewing the tables to see whether we want to add additional information, but at this point I would expect we would kind of follow the access reports that have been done over the last five years or so.

DR. CURRERI: If you found an access problem would you envision, or would it be likely that HCFA would recommend budget neutral alterations of the RVUs? I just don't have any idea what you're planning on doing if there's an access problem.

MR. KAY: I think we'd have to sort out what the mechanism is. Under the fee schedule and the statute, to the extent that were an access problem and that was a flag for potentially mispricing of some code, we would have the ability to do a budget neutral re-valuing of those services. I think if it was something broader than that it would probably be a statutory issue.

DR. WILENSKY: I assume, Bill -- I'd like to follow on with this -- that the issue that some of the specialists have raised to, at least in the preliminary version we're going to see very substantial reductions in fees that they generally receive -- particularly some of the specialists who are heavy doers of a limited number of procedures -- that the notion of having an access problem in a program in which to date at least there has been very little indication of access problems, took on a whole different dimension when you're talking about 25, 30 percent reductions. Particularly when you combine the various changes that were potentially out because of the other changes that were occurring contemporaneous or would be contemporaneous with the practice expense.

So to the extent that HCFA can have at least ready suggestions, since by the time we can document it we'll probably be hearing loudly from those affected and well into the change, it would strike me that if, in part it will depend on how much empirical modification results from the rule that is going to come out.

If the kinds of changes that are being proposed are more modest relative to what was appearing before, it may not be quite as urgent, although still probably important. If the kinds of changes appear, again, to be very substantial then it would seem prudent to have in your back pocket what you would do if in fact there is a major impact on the availability of certain specialty services as opposed to geographic problems, which also could occur.

DR. ROWE: Gail, isn't there supposed to be some sort of a cap on the amount of change there would be in one direction or another? Would that be relevant to your comment about --

DR. WILENSKY: There will be a phase-in. I don't know whether as part of the phase-in -- but I don't know that it will make much difference over a three-year period.

MR. KAY: Right, the statute is a four-year transition so that by the fourth year the new values would be implemented fully. Within any one year there's no particular ceiling or cap on the changes other than it would be a maximum of 25 of the change.

DR. ROWE: Right, but there's no dollar cap.

MR. KAY: No.

DR. ROWE: Or a threshold or a ceiling or whatever, or a floor.

MR. KAY: No.

DR. WILENSKY: What I'm thinking about were, again, seeing the tables as they originally came out with, I think it was either cardiovascular or thoracic surgeons were among a couple of specialties that were showing very substantial declines, and if it looked like that produced what in fact has been talked about previously but not in fact observed, which really is access problems for certain specialty procedures, what would be the recommendations to try to ameliorate them?

DR. CURRERI: But I think you even have to take those figures and add on 10.4 percent more because of going from the separate surgical conversion factor to the common conversion factor. So you're really talking in cardiothoracic surgery, for instance, estimated 46 percent decrease over four years which is 12 percent a year.

DR. WILENSKY: We're just saying that to the extent that we're now talking about much larger values than has occurred because of all of the change that occurs during the same period, thinking about what could be done with existing statute and what could be done with new statute would be appropriate. We obviously will try to think about some of the same issues. It really does seem that the potential for having access problems is at a very different level from what we have observed in the past because the size of the changes are so much greater.

DR. ROWE: But I would think also in this case -- this is very interesting, but given the potential size of the effect, for instance, in CT surgery. On the other hand, you're dealing with a specialty in which there's probably an excess capacity in the country. I don't know that for a fact, but my guess is we have as many cardiothoracic surgeons as we need. Maybe not perfectly distributed, but I think we have a couple extras in New York City, for instance.

So access is going to be a function of not only payment, but also what the market is like. And if you have a specialty where you really have many more people than we think we need then you're going to have less of an access problem I think.

DR. CURRERI: There's no question -- and I agree with Joe, too -- that we are likely to see this in pockets where you have an undersupply where people can be selective, because none of those cardiothoracic surgeons in New York are ready to move to Montana.

DR. ROWE: A lot of them are, but they're all retiring.

DR. WILENSKY: They may be soon.

DR. LAVE: They may want to eat.

DR. ROWE: But that's, I think, the point. What I'm saying is that you might force redistribution out of a maldistribution because of this.

DR. LAVE: The other issue is whether or not there will be more pressure from private contracting on some of these, which I think is another --

DR. WILENSKY: Any additional questions to ask either Bill or Terry?

Thank you very much. We look forward to the May 1st rule.

We're going to have a public comment period on this area.

DR. NEWHOUSE: Anybody like to comment?

[No response.]

DR. NEWHOUSE: Everybody is waiting for the rule. Why don't we take a break and start again at 3:00?

[Recess.]

DR. WILENSKY: Let's reconvene. As those of you who were here this morning know that we are not about to talk about the BBA implementation schedule. I apologize if some of you came to hear that. You can download the discussion of this morning from the MedPAC web site whenever it gets up there, which I assume will be sometime soon. Instead we are going to have our discussion about the relationship between hospitalization and post-acute care utilization, which is under Tab B for the commissioners.

Craig?

MR. LISK: Good afternoon. I'm going to be reviewing the chapter on the relationship between hospital and post-acute care provider that will be included in the June report. That material, as Gail said, is in Tab B of your briefing books.

In this chapter we discuss how hospital care and post-acute care provider use relate to one another. Much of the work included in this chapter updates work conducted by ProPAC two years ago. The focus of this analysis I will present to you this afternoon is basically on the hospital. Future analyses, we will look at further patterns of patient care, patterns of care taking place in individual post-acute care providers. There's also more to be learned in studying the hospital level data that we're showing you today.

The chapter starts with a discussion of some of the basic issues concerning post-acute care and its use for Medicare beneficiaries, it's rapid growth, and factors contributing to that growth, issues about choice of post-acute care setting, post-acute coverage policies, the geographic availability of post-acute care services, and patient factors affecting use of post-acute care providers. The beginning of the chapter then reviews some of the requirements of the Balanced Budget Act concerning policy modifications for post-acute care services and the development of new payment systems for these services.

Before discussing the findings I want to briefly review some specific details of how the analysis was conducted so you can have a better understanding of what the numbers really mean.

The analysis is based on fiscal year 1996 Medicare claims data with some comparisons to fiscal year 1994. The analysis was limited to four types of post-acute care providers, skilled nursing facilities and discharges to hospital swing beds, PPS-excluded rehabilitation hospitals and units, PPS-excluded long term care hospitals, and home health agencies. Some part of the analysis also include psych hospitals in the analysis where relevant when we talk about transfer policy.

PPS hospital stays where the beneficiary died in the hospital or resulted in a transfer to another PPS hospital are excluded from our calculations of post-acute care use since by definition

these cases cannot use post-acute care services.

Because of how we initially constructed the analysis files, use of long term care hospitals and rehabilitation hospitals is underestimated. This is because we do not capture post-acute care that started in fiscal year 1996 but ended in fiscal year 1997. We had the ability to adjust the utilization rates for the '96 data to partially correct for this problem, but thus far we have not had the time available to do that.

The '94 data we are comparing to though cannot be adjusted very easily since we'd have to rerun the analysis files in order to do that.

Home health utilization is based on home health episodes that start after the beneficiary was discharged from the hospital. Thus, we do not capture home health use that started sometime before the beneficiary was hospitalized, if that in fact occurred. We plan to address this issue in the future to capture current home health users in this type of analysis but we will be unable to address this for this year's June report.

In most of the chapter we examine the use of post-acute care providers immediately after a hospital stay. In other words, within one day of discharge. One day is examined because these are the cases where substitution of inpatient care for post-acute care provider is most likely. We also include in the 30-day window some parts of the analysis because this is the standard that determines whether skilled nursing facility care is reimbursable by Medicare. In most of my discussions I will be referring to immediate use rather than use within 30 days. I will mention instances where we're talking about use within 30 days rather than immediate, more specifically.

In fiscal year 1996, 20 percent of all PPS hospital discharges went on to receive services from a post-acute care provider within one day of hospital discharge, and an additional 5 percent of Medicare inpatients starting receiving post-acute care services two to 30 days after leaving the hospital. Thus most of what we define as post-acute care occurs immediately after the patient leaves the hospital.

If we look at the type of provider used we see that skilled nursing facilities accounted for about half of all discharges to post-acute providers. In fact, 11 percent of all hospital discharges were followed immediately by a skilled nursing facility stay.

Home health care agencies were the next most frequently used type of post-acute care provider with 9 percent. Unlike skilled nursing, a sizeable proportion of hospital stays, 7 percent were followed by a home health episode that started between two and 30 days after the hospital stay. Thus, home health care is the most frequently used provider if we look at a 30-day window.

Many of you will probably notice that the right-hand column does not add up to 27.9 percent, and this is because this table captures multiple post-acute care providers. So it is identifying the proportion of discharges that were followed by use of a particular type of provider and we're capturing people who use more than one type of provider there. So someone who went on to use a SNF and then went on to use a home health provider.

DR. LONG: More specifically, Craig, of that 7 percent that start home health after the first day but before the 30th day, how many of that is preceded by another post-acute care provider?

MR. LISK: 40 percent of those.

DR. LONG: So 60 percent of that 7 percent are first use of any post-acute care provider?

MR. LISK: Approximately, yes. And as you see, about 3 percent of rehab stays, of discharges that are followed by a rehabilitation stay, and less than one-half a percent are followed by a long term care hospital stay.

Next I want to discuss the growth in the use of post-acute care providers after a hospital stay. From fiscal year '94 to '96, the proportion of hospital discharges followed immediately by a post-acute care provider grew by 5 percent. Growth rate varies across provider types. The proportion of discharges followed by a long term care hospital stay climbed 50 percent, which may be partially attributable to a 27 percent increase in the number of long term care hospitals over that period.

The proportion of discharges to rehab facilities increased by 13 percent. The growth in home health and skilled nursing facilities was much lower at 2.6 and 4.4 percent, respectively. It's important to point out here though that despite this lower growth for home health and skilled nursing, Medicare spending growth for these two providers still climbed at more than 35 percent over that two-year period. Much of the spending growth was attributable to increases in the number of days of service per user rather than increases in the number of users. And also in the intensity of those services provided.

DR. ROWE: That would make sense, Craig. This is a little surprising when you look at the proportion in decrease in the length of stay that occurred this period of time. You would assume there was a trade-off with more people getting home care as the length of stay was falling quite dramatically. But I guess what you're saying is, those people were on home care anyway, they're just now getting more days of home care so they don't show up in this.

DR. WILENSKY: That's only true if you look at '94 to '96. If you look at the last decade it doubled.

MR. LISK: That's correct. I'm just looking just at this narrow period --

DR. ROWE: First they got on home care, and now they're on it longer as length of stay falls even more.

MR. LISK: Right.

MR. SHEA: The incidence of use of home care doubled you say in 10 years?

DR. WILENSKY: The incidence and the number of visits per user.

DR. ROWE: Doubled.

DR. WILENSKY: Both doubled; each doubled.

MR. LISK: Now moving on to multiple use.

It's not an uncommon occurrence that a beneficiary will use more than one post-acute care provider within 30 days of discharge from a hospital. In fiscal year '96 almost 18 percent of beneficiaries who used a post-acute care provider immediately after being discharged from the hospital subsequently used a second post-acute care provider within 30 days of the hospital stay. The prevalence of this second use varied according to the type of post-acute care provider initially used.

As we can see here, almost half of all post-acute care rehab stays were followed by use of a second post-acute care provider, and close to one-quarter of post-acute SNF stays and long

term care hospital stays were followed by post-acute hospital use. Less than 1 percent of post-acute home health episodes, however, were followed by another post-acute provider stay.

The most frequent combinations of multiple post-acute provider use were for SNF stays followed by a home health episode, and rehab stays also followed by a home health episode. Then the next most frequent combination actually is skilled nursing followed by another skilled nursing stay, either the person going to a different skilled nursing home or being discharged to home and then having to be readmitted back to the skilled nursing facility.

Next I want to turn to the type of inpatient cases that typically are followed by use of a post-acute care provider. We have broken cases into two groups, DRGs where a large proportion of discharges go to use a post-acute care provider and DRGs where the largest number of discharges go to post-acute care providers. Some of the DRGs we see will fall into both groups.

There were 12 DRGs where more than half the discharges in those DRGs went on to use a post-acute care provider within one day of the hospital stay. We have the top five here on the chart. The DRGs that fell into this group appear to be similar in many respects. Most of these cases fall into DRGs related to musculoskeletal related conditions and procedures such as hip replacements and fracture of the hip and femur, but it also includes tracheostomy cases as well.

The DRGs responsible for the largest volume of post-acute providers is much more heterogeneous. While there is some overlap between the two groups in DRGs 209 and 210 for instance, major joint and limb procedures and the hip and femur procedures, there's also strokes, heart failure and shock, and simple pneumonia, and those cases, it's a much more heterogeneous of cases that make up the high volume group. The five DRGs that are up here on the slide account for 30 percent of all post-acute care provider use immediately following a hospital stay in terms of the start of those episodes.

Now growth in the use of post-acute care providers varies by DRG. Compared with fiscal year '94, the proportion of cases in a number of DRGs for hip and femur related procedures and diagnosis actually fell as use group for a number of cardiac related DRGs and also for mastectomies, grew quite significantly. About 35 percent of DRGs had more than a 10 percent increase in the proportion of cases using post-acute care immediately after discharge, and about 6 percent of DRGs had an equivalent decline. So there's a lot more growth going on in a lot more DRGs.

Our analysis does show that the type of care required may affect the post-acute setting the beneficiary uses. Many of the top overall post-acute care use DRG are also top use DRGs in each of the four post-acute settings. Major joint procedures, for instance, are among the top three DRGs in all four post-acute settings we are looking at. Stroke is almost among the top three DRGs in SNFs, rehab, and long term care hospitals, but it's lower down the list for home health care.

Certain types of cases though tend to gravitate to particular types of post-acute settings. Skilled nursing facilities receive a large share of the musculoskeletal and respiratory type diagnoses and relatively few of most of the cardiac related diagnoses. By contrast, home health care providers receive a large share of the cardiac related cases and also mastectomies, for

instance.

Home health care also tends to be the most prevalent post-acute care provider in DRGs with relatively low post-acute care use rates, which you likely would expect. Long term care hospitals receive a fairly substantial share of patients for patients requiring ventilator support. That's in DRGs 483 and 475. But otherwise the types of patients seen are spread over a large number of DRGs in those facilities.

Rehab facility stays though are generally preceded by DRGs that require some post-hospital rehabilitation therapy which includes strokes and hip fractures and hip replacements. The types of cases that tend to go into these facilities, therefore, is much more limited compared to the other types of facilities.

The relationship between post-acute provider use and acute inpatient length of stay may suggest important differences in patient population or patterns of care. In most DRGs, beneficiaries who use a post-acute care provider immediately after a hospital stay had longer inpatient stays than those who did not. This likely indicates post-acute care users were sicker than non-users. In general, in the average DRG, people who use post-acute care had inpatient lengths of stay that were 2.2 days longer than for those who did not use post-acute care.

There are only a handful of DRGs where lengths of stay were either similar or less for post-acute care users, and these include the five DRGs with the highest proportion of cases going on to use post-acute care providers. General treatment protocols may have been set for this group of cases and that may be why we see shorter hospital stays for that particular group.

In addition, there are a number of psychiatric DRGs where beneficiaries who use an excluded psych hospital or unit or some other post-acute care facility had shorter inpatient stay as compared to those who did not.

In our analysis we also examined how inpatient length of stay changed between fiscal year '94 and '96. Here we can see that beneficiaries who use post-acute care providers immediately after discharge had a bigger day drop in length of stay than for cases that did not. The greater drop in length of stay is likely due to two factors. One is that post-acute care use is maybe beginning earlier in a patient's stay, decreasing the time these patients spend in the hospital. And the other is that more beneficiaries are using post-acute care services, thus less severely ill patients may be using post-acute care services, which is lowering the average stay for both post-acute care users and non-users.

DR. ROWE: And the baseline was not significantly different from the previous slide in these two groups? It's not like the reduction was greater in those that use post-acute care because they had a longer length of stay to begin with, right?

MR. LISK: They had a longer length of stay and the percentage reduction generally was larger for those who use post-acute care, but it wasn't consistently larger. The day drop though was consistently always larger for the top 20 DRGs. The top 20 DRGs it was always at least two-tenths of a day larger and as much as three days larger in terms of the day drop.

DR. LAVE: The base rate is '96, Jack. It wasn't '94. I thought you were looking at comparable to the base rates. They were the same in 1996. They weren't necessarily the same in the 1994.

DR. ROWE: In 1994 it might have been a bigger difference. I would add to your reasons for the observation of more prevalent use of care plans where you get almost a regression to the mean phenomenon, but the ones with the longest lengths of stay are the ones that have the greatest reductions.

DR. MYERS: I would be rather careful in making the interpretations like we're making. We're making an assumption that the input is the same and that for each of these procedures, the same indications for the procedure, the same level of illness for the procedure, that indicated doing it in '94 is the same as '96, and I don't think we can say that. Not just with technology changing, but with more aggressive marketing, lots of things are happening that prevent us from making an apples to apples comparison like this.

So I would be careful in attributing length of stay drops. The healthier the patient who's coming in the door, the less likely they are to need any services after they've had the procedure. In addition, you don't know whether or not something in that stay made them sicker as opposed to whether or not they were sicker coming in the door. Some of the people that are going into the post-acute setting could have had complications related to quality within the stay as opposed to having walked in with comorbid conditions.

DR. WILENSKY: Why do you think that changed in two years between '94 and '96?

DR. MYERS: No, what I'm doing is proposing alternative theories as to why the drops or the changes have occurred.

DR. ROWE: I think that's a good point, Woody, for certain diagnoses. The technology and the marketing and all of that might have an influence on the first one there, which is having a major joint replaced, but probably not on the second one, having a stroke. We're not having healthier people have strokes. You have a stroke and you show up in the hospital. But the marketing piece might be relevant to somebody who's going to have --

DR. MYERS: On the elective procedures.

DR. ROWE: -- that wouldn't have otherwise.

MR. LISK: Actually, you see the day drops are closer for some of those high use cases in terms of the major joint and hip and femur procedures.

Let's go on and talk about variation in use by beneficiary characteristics. In the next part of our analysis we examined the relationship between beneficiary characteristics and use of post-acute care providers. Here we examined the percentage of cases that immediately use a particular type of post-acute care provider by beneficiary, age group, and gender.

DR. LAVE: Craig, is there any way -- I've made this point before, but to make sense of these data I think you have to control by where they started from. Because if I start from a skilled nursing facility, I'm going to go back to a skilled nursing facility, and my guess is that most people who come from a nursing home in fact they're going to be discharged back to a nursing home. The question is whether or not they get discharged back to skilled care. The probability is that they will get discharged back to skilled care.

So when I look at these high rates, it seems to me that we really have to be very careful --

MR. LISK: But it is a fact that these patients are using the skilled nursing benefit in terms of what their residence are, and that is one factor that may be influencing that; they may be using

that use. But they would not have been a skilled nursing patient --

DR. LAVE: They might not have been any patient.

MR. LISK: Right.

DR. LAVE: I just think that it is so mixed up in trying to understand what's going on. My guess is that these pneumonia patients -- anybody probably can use a service, and it's a little different I think. And I think for us to understand what is happening with the use of post-acute care it really is important to know whether or not you're talking about somebody who's coming in from the community and then there may be a certain degree of discretion about which type of service to use and somebody who's coming from a nursing home with a 100 percent probability he's going to be discharged back to that nursing home.

MR. LISK: That's right, there is a problem in being able to identify those patients for this particular type of analysis. We can do more limited analysis using the Medicare current beneficiary survey and looking at that. But the accuracy of where they came from to the hospital stay, that record field, that's probably what you're talking about that's on the MedPAR file has not proved to be very reliable.

DR. LAVE: But suppose if they say they came from a skilled nursing facility. They might have come from someplace else. I never can remember the difference between specific and sensitive, but it's perfect in one dimension and terrible in another. And if everybody who they said came from a skilled nursing facility actually came from a skilled nursing facility, you could look at that group anyway and see what it looks like to find out what the nature of the problem that you have in looking at these data, whether or not it's something to make sense of post-acute care we should have more information about.

MR. LISK: As we were saying in terms of looking at age, we're thinking of age as a potential proxy for patient severity here. Past research has also found that post-acute care use rates vary by gender, which may reflect differences in the availability of family support in the home, but also age as well.

DR. ROWE: In this regard is age, Joe, as one of the experts on risk adjustment, the age effect here looks like it's a more potent predictor of this use than it does for other services; is that right?

DR. NEWHOUSE: More than total dollars, although the issue would be the variance each of these categories.

DR. ROWE: We were talking earlier about using age as a proxy and people said it's not that good a proxy. But here it certainly --

DR. WILENSKY: You don't know if it's a good proxy. All you know is there's a linear relationship. But those averages might be all over the board.

DR. ROWE: The standard hourly estimates.

DR. WILENSKY: We just don't know anything from that.

MR. LISK: But as you can see here we do have a strong relationship between age.

DR. NEWHOUSE: This is also just percent use. It's not any kind of dollar number.

DR. ROWE: I understand.

MR. LISK: But it does show that those over 85, about one-third of them go on to use

some post-acute care after discharge, immediately after, compared to one in ten for those under 65.

DR. ROWE: But some of these may be the ones Judy is talking about who were in nursing homes before.

MR. LISK: That's true.

DR. CURRERI: I would suspect that a large proportion of these may be home care. Do we have any idea--

MR. LISK: We'll go on to the next slide and we can show you what happens here when we talk about different types of post-acute care. The type of post-acute care also varies with age, and home health care was the most frequently used post-acute care service for younger beneficiaries, whereas SNF care was the most common for older beneficiaries. Use for each type of provider generally increased with age except that the percentage of 85-plus beneficiaries that used home health, rehabilitation, or long term care is lower than the 75 to 84 age group. So that actually dropped down for those beneficiaries after their discharge.

The greatest difference in use rates across the groups is for skilled nursing. Basically that's what that last graph really showed was really a skilled nursing effect where we see that about 4 percent of beneficiaries discharged from the hospital who were under 65 went on to use a SNF compared to 23 percent of those over age 85.

DR. CURRERI: Do we have any idea of how many people under the age of 74, for instance, had home health agency only for housekeeping duties versus actual delivery of health care?

MR. LISK: In terms of part of what we're -- a future analyses we'll be looking at is what happens within an individual episode for, let's say, what happens in the home health stay in terms of the number of visits, the type of visits, and those types of things. Louisa Buatti will be presenting some information at the next Commission meeting on that, but there's a lot more work we will be doing describing that for all different types of post-acute care providers, for what those differences are potentially by age and stuff.

DR. LAVE: But they can't have housekeeping services only because they have to qualify for some skilled nursing.

MR. LISK: That's correct.

DR. LONG: Craig, would the anomaly in the home health agency column reflect the fact that a greater proportion over the age of 85 aren't at home and therefore can't have home health agencies?

MR. LISK: It could be that. It could be also that the primary caregiver in a home is less likely to be there when a person is over age 85 as well, in terms of a spouse for instance. So there's probably a combination of factors that may be happening. So I don't know in terms of those who live at home, if we adjusted for that what that effect would be. But I imagine there's a double effect there, both institutionalized but also not having a spouse that would also be able to care for the patient effectively.

DR. ROWE: In that age group, Hugh, the prevalence of a significant cognitive defect would be about 50 percent. So that many of those individuals during a recovery period just

cannot be managed at home even if there is a spouse or family member because of that cognitive defect. There's a striking relationship with age and prevalence of, say Alzheimer's disease; 4 percent at age 65, 45 percent at
age 80 in some studies.

DR. NEWHOUSE: That's a rather discouraging number.

DR. LONG: This is not good news, Jack.

DR. LAVE: That's depressing.

DR. ROWE: It's a challenge. That population, those data do not include studies of former PPRC or ProPAC members, which would be a special population.

[Laughter.]

MR. LISK: Let's go on and talk about the growth by age groups. Between '94 and '96 there was a difference in the growth rates in use of post-acute care providers after hospital stay by beneficiary age. Post-acute care use rates grew for younger beneficiaries and fell for the oldest. Use rates grew by 16 percent for the 65 to 74 age group, by 6 percent for the 75 to 84, and then fell by a little less than 2 percent for those over age 85. The greater growth for younger beneficiaries is consistent with expanding use of post-acute care across a more diverse set of cases I think.

DR. ROWE: Is that age adjusted within those groups?

MR. LISK: No.

DR. ROWE: Because with the aging of this population, the average age of the people over age 85 is higher than it was before. The average age of the people in the 75 to 84 may be --

MR. LISK: Right. The difference over two years probably is going to be relatively small though for that effect. Now of course, you have to remember too though is what we have is we're throwing out -- we don't include the people who died in the hospital.

DR. CURRERI: Are they no post-acute care?

MR. LISK: They're not included in the denominator of the analysis because theoretically they can't, although there may be some records that show, a few that show that they did use post-acute care services, but those are probably data anomalies on the MedPAR. And then theoretically, people who were transferred can't use post-acute care because they're going to another hospital. So they can use it after that other hospital stay and that's where we capture it.

Next we examined the use of post-acute care providers by some hospital characteristics, and here we do see some variation. In this part of the analysis we compare hospitals post-acute use rate to its expected use rate given the mix of DRGs present in the hospital. Controlling for the mix of cases, rural hospitals use post-acute care for about 11 percent fewer patients than otherwise would have been expected given the cases they received. Now compared with hospitals in the large urban areas, they had about an 8 percent higher use than would have been expected.

The difference may be the result of the availability of post-acute care providers in those different settings, locations.

Now teaching status does not appear to be a factor in affecting post-acute care use. There's only small differences observed there. Use after discharge from a government hospital though is substantially less than expected given the mix of cases in those hospitals.

DR. LONG: Any theory on that?

MR. LISK: No. If someone wants to express a theory, I'd be glad to, but I don't want to speculate on it.

DR. ROWE: If somebody goes from a VA hospital to a VA nursing home --

MR. LISK: VA isn't included here though because these are Medicare patients.

DR. ROWE: So what's a government hospital?

MR. LISK: A government hospital would be Cook County.

DR. ROWE: I see, local --

MR. LISK: Local or state.

DR. ROWE: And Health and Hospital Corporation?

MR. LISK: Health and Hospital Corporation hospitals, yes.

DR. CURRERI: Have these numbers been statistically tested? Is there really any significant difference between 19.8 and 22.3?

MR. LISK: No, I have not. This is the full universe of hospitals though too. So it's not sampling statistics here.

DR. CURRERI: So these are millions of people; is that right? So that's probably significant.

MR. LISK: Now the other thing we looked at was by region, and there was substantial variation in use by region. We see patients discharged from hospitals in New England use post-acute care providers 32 percent more than expected given the mix of cases, for 30 percent of the cases discharged there. The use was also higher than expected in the Middle Atlantic and Pacific regions.

DR. WILENSKY: What's going on in Alabama?

MR. LISK: Yes, down in the east south central, use is much lower than expected and it's a lot of those specific southern states, Mississippi, Alabama, that are captured there that have much lower use rates.

DR. LONG: How about Florida?

MS. MAXWELL: Those are states also that have the preponderance of outpatient rehab sites, which may be picking up some of that difference.

DR. CURRERI: But they're also large rural populations where facilities aren't very plentiful.

DR. LAVE: The other thing is, if you bought my nursing home argument, these are also states with a large proportion of African-American seniors and they don't tend to use nursing homes so much. So you may have fewer people coming into the nursing homes, therefore fewer people going back.

MR. LISK: I don't think that explains the substantial differences we see though. There's some states like Rhode Island, individual states like Rhode Island where the use is about 40 percent of the cases -- Rhode Island and Massachusetts I think about 40 percent of the cases go on to use some sort of post-acute care afterwards, and Connecticut where it's up about 35 or more percent; substantial. Then in some of those southern states where it's down around 15 percent. I mean, substantial variation.

DR. MYERS: Have you looked at these issues by race?

MR. LISK: No, we have not yet.

DR. MYERS: Or by gender?

MR. LISK: We have looked by gender.

DR. MYERS: Are you planning to look by race?

MR. LISK: Yes, we can. We can if there is need. We did not at this point in the analysis.

DR. CURRERI: Have you compared the states where there was a low actual use and those with a high actual use to see whether there was a difference in hospital length of stay in those cases?

MR. LISK: No. There's a lot more that we can do in looking to try to explain some of this variation in use and we haven't had the time really to do that. And ideas that people think might be important you should express to us and we can put it on our agenda for looking at those types of issues. Because there's a lot of information we can with the database that we have, that we've created, to find out. If we think that those are important factors, we can do a lot with them.

MR. MacBAIN: Craig, do these differences hold up across all four provider types or is it concentrated in just SNF and home health?

MR. LISK: The use does track. Rehab hospital use is higher in areas that have rehab hospitals, for instance. I mean, it does track to availability. Home health is available pretty much all across the country, although there may be rural-urban distinctions with home health.

MR. MacBAIN: And licensing differences, and competitive issues, marketing issues.

MR. LISK: Right. But there is some track to the provider and use. What I was going to talk about next just briefly -- and this is stuff that we'll go on to do some more analysis of in the near future -- is we --

DR. WILENSKY: There's another question before we go on. Alice?

MS. ROSENBLATT: I was just going to suggest that you run this chart using the age brackets that you had used because my guess is some of it may just be an age variation.

MR. LISK: From previous ProPAC analysis we also know that post-acute care is related to hospital ownership of post-acute care providers. We plan to do more analysis on this. In the fiscal year '94 analysis that we had done, use of post-acute care providers was about 10 percent higher in hospitals that owned a post-acute care provider. Beneficiaries who used post-acute care in those facilities also had shorter acute inpatient stays when they were treated in those hospitals.

Now we don't know in those cases whether they actually used the specific post-acute care provider in that hospital, but there is a strong relationship to ownership and higher use and shorter inpatient lengths of stay. And we plan to update that part of the analysis in the near future, but it will take a little bit more effort.

I was going to go on and then discuss the transfer policy. The next part of the analysis looks at the BBA's extension of Medicare's transfer payment policy to include discharges to post-acute care settings. The Balanced Budget Act of 1997 expands the definition of cases that would be considered as a transfer to include cases that are subsequently to a non-PPS hospital or a unit or skilled nursing facility or use of hospital swing bed. And beneficiaries who received home

health services from a home health agency would also be included in the expanded definition if the services they received are related to the condition or diagnosis of the inpatient stay.

Previously, a case was considered transferred only if the patient was discharged from one PPS hospital and immediately admitted to another PPS hospital. In the upcoming proposed rule for PPS inpatient payments, the Secretary will select 10 DRGs where subsequent post-hospital use of a post-acute care provider will classify the case as a transfer for Medicare payment.

Transferred cases are paid a per diem payment. The per diem payment is determined based on a dividing the full DRG payment for the case in the hospital by the geometric mean length of stay for that DRG. Hospitals received twice the per diem payment amount for the first day of care and the per diem payment amount for all subsequent days of care up to the full DRG payment for the case, depending upon the length of stay.

Under the new rule expanding the definition of transfer, the Secretary can provide a modified transfer payment in DRGs for which a substantial portion of the cost of care is incurred in the early days of the inpatient stay. The maximum amount of this modified payment is the average of the transfer payment and the full DRG payment.

This new transfer policy will only affect payments for cases that have stays more than one day below the geometric mean length of stay for the case. So only a small portion of cases, therefore, will be affected by this policy. If this new transfer policy had been applied to all discharges that immediately used a post-acute care provider or other PPS-excluded hospital in fiscal year '96, only 23 percent of the cases would have had payments reduced; roughly 5 percent of all PPS inpatient cases.

This proportion of cases affected by the transfer policy varies by DRG. As we show in the overhead here, the potential financial impact also varies by DRG. What we have in the overhead here is the DRGs with the greatest financial impact from the transfer policy if implemented on these DRGs, but across all cases. We didn't limit it to 10. So the percentage in the right-hand column is the total reduction in payments if the transfer policy were applied to all DRGs.

So the largest financial effect in dollars would be among tracheostomy cases in DRG 483, which alone would account for one-sixth of the potential reduction in payments in that DRG. Now tracheostomies is a DRG with a very high weight and a very long length of stay. What probably would happen here is there are many cases that have five, six days rather than the 44 length of stay that's the average for that DRG. And if a hospital is able to put a trach into the person for someone who needs that and then discharge to a facility that has the capability of handling someone on ventilator support, the hospital currently receives a full payment for that case.

So under the transfer policy that HCFA -- that was passed in the BBA, that case would receive per diem payments for those days of care, because there's a great differentiation then between a case that stays in the hospital for that full length of stay versus those that are sent out earlier.

One of the issues the Commission may want to comment on in the report in the coming regulations is the specific DRGs that HCFA should include in the initial list of 10. Table 14 in your briefing materials lists three different groupings of DRGs: those with the potential greatest

dollar impact, which is what's on the overhead here, those with the highest volume of post-acute cases, and those with the greatest proportion of cases going to post-acute care. While there's some overlap among these groups, they aren't the same and you can go about picking your list in a number of different ways.

HCFA has a list of 20 DRGs currently from which 10 will be included in the proposed rule that is due out shortly. HCFA used a combination of high proportion and high volume of post-acute cases to select their DRGs. So they basically ordered DRGs by the proportion and then had a minimum criteria for selecting, volume criteria and the number of cases that went on to use post-acute care to select their cases for that list.

There are a few DRGs that aren't on one of our top 10 lists, but all those DRGs HCFA has included had a relatively large proportion of cases using post-acute care with a relatively large number of cases. And all 10 of these DRGs that are on this high impact list are on HCFA's list.

HCFA's list of 20 also includes a wide range of cases, which could be considered desirable to test this new policy before the transfer policy is potentially expanded to more DRGs, if that's what happens in 2001 when the Secretary has the ability to do that.

If the transfer policy were implemented across all DRGs, 46 percent of the cases that had a reduction in payments would have payments reduced by less than one per diem payment; 80 percent would have a reduction in -- would have payments fall by less than two per diem payments. So the amount of reduction in terms of per diem payments would be relatively small.

But if the marginal costs of care in the per diem payment are fairly close, the hospital likely would be indifferent to the decision to transfer the patient to a post-acute care setting. Hence, the decision to transfer a patient would likely be based on patient needs and not hospital finances, for instance. Currently, there is much more of an incentive to transfer patients because receiving the full DRG payment.

The transfer payment may need to be modified over time so it can track marginal cost better, but the double per diem payment for the first day of care followed by per diem payments provides a pretty good proxy of marginal cost. It may over-estimate marginal cost for later days, but that system is not -- the per diem payment system that's currently in place is not set in law. It's something that can be worked on and that HCFA can eventually modify and be worked on to come out to something that would be closer to marginal cost in these cases.

The basic principle of Medicare's transfer payment policy is that hospitals should be indifferent to decisions to transfer patients. If the most appropriate setting for care is somewhere else, then the hospital should not be penalized for sending the patient to that other setting, but neither should the hospital be disproportionately rewarded for doing so.

The basic idea behind Medicare's transfer payment basically is that if the full care regime is not provided in the hospital, the hospital should not be paid as though it provided the full regime of care. So what the BBA does is just extends that policy to use of post-acute care.

I want to go on to basically the conclusions. The data we just presented to you show how post-acute care has become an important part of the continuum of care. Changes in payment policy likely could affect when the care is provided, where it is provided, and how it is provided. Assessment of changes is complicated by the overlap of services across the different types of post-

acute care providers as we saw in this analysis. Different types of post-acute care providers can treat the same types of patients. We do need to know more about those differences though.

In addition, we have shown how the payment systems currently are not linked and the expansion of Medicare's transfer payment provides a start in developing a link between inpatient care and post-acute care. HCFA has a major undertaking in developing prospective payment systems for a number of different types of post-acute care providers over the coming years and in the very immediate future.

Among the issues that need to be considered are the development of policies that encourage providers to control the number and intensity of services furnished, and this is important since this is where a lot of the growth in post-acute care provider use is occurring. This will require the development of common and compatible patient assessment tools, and these are being worked on currently, which will allow for the development of consistent payment methods across different post-acute care settings. Methods for tying all these payment systems together, including the connection to inpatient care, will also need to be considered.

So the Commission will need to provide input in this process as policies and payment systems are developed, and be able to evaluate the impact of policies once implemented. So as you can see, there's a lot of work to do that will need to be done by the Commission in the future. So what we presented you with today and we'll include in the June report will really provide some initial background and a framework of reference to look back on as changes occur in the near future.

I'll be happy to answer any questions and comments on specifics in the paper and the report.

DR. WILENSKY: We've had some specific questions, but this is now general question time for the commissioners.

MR. MacBAIN: A couple of things. One is, not being a mathematician, I'd be interested in some comments on whether the geometric mean is the appropriate denominator to figure out the marginal per diem cost.

MR. LISK: Right. HCFA when they revised the transfer policy, and ProPAC had done some work on this back a number of years ago and had pushed for HCFA to actually change the transfer policy to do something that reflected the higher cost on the first day of care. Actually, Joe had done some of the initial work on that I think when he was at RAND for some analysis that HCFA had done.

But the most recent work that RAND did for HCFA in developing the new transfer policy -- this is the policy that was implemented a few years ago back, not the expansion of the transfer policy -- for doing the double per diem payment for the first day did show some evidence that basing it on the arithmetic average might be better in tracking marginal cost, but that the double per diem payment was better on the first day in terms of tracking cost of the first day.

So there was a trade-off in terms of the second day, and they wanted something simple rather than something that was a double per diem the first day, 1.5 times the per diem for the second day, and then something less than the per diem for days after that, which probably would be more accurately track those costs.

MR. MacBAIN: The other point is that with the prospective payment system we ended up with a payment approach that specifically eliminated indifference to the marginal days at the end of a hospital stay to try to stimulate changes in practice patterns and technology. Are you concerned that now by reintroducing indifference we begin to institutionalize the status quo?

MR. LISK: Some of that is probably a discussion for the Commission to have. But what happens is that you may have had -- what may be too strong an incentive to use those other types of care. The concept of the transfer policy when -- the initial transfer policy, in having a per diem cases was that when a patient is transferred to another hospital, the full regime of care wasn't provided in that hospital, so it was appropriate.

Now as post-acute care settings are getting more complex and able to provide that care, it's almost -- in some respects it's the same type of thing as a transfer to another hospital. It's a less acute type of care, but a lot of that care was previously given in the hospital, but the ability to provide that care somewhere else has developed. So you can adjust it by a transfer policy, or you can adjust it across all cases with much lower updates, for instance, or a combination of both.

MR. MacBAIN: It may well be that we want to see this continue, see this downward progression of the swing technologies to a lower level of intensity. If that's true, then if we create indifference at that point of decision, whether to stay another day or to transfer, we're going to freeze things where they are. It would be interesting to watch these 10 DRGs and see if further technological advances that could discharge patients sooner to a lower level of intensity suddenly get stopped.

DR. NEWHOUSE: That will also presumably depend on the reimbursement policy on the post-acute side.

MR. JOHNSON: I just find this one particular frustrating, but this is one where I think the issue of looking at the broader context is important because obviously as the program went into place they were trying to enforce certain behaviors. But as for example, we want systems of care, we want patients to move along a continuum, we want the right care at the right time at the right place at the appropriate cost and quality -- remember all that?

And the fact that maybe not even just hospitals but systems would own a continuum of care, and one could sit back and look at other issues in addition to cost such as quality and access. Where do you want these patients to enter, or where do you want them to exit? How do you want them to effectively move along that continuum with the best standard of care and the best outcome?

Yet I can see where we're going to take these small, incremental snapshots and whether we're disrupting that policy of trying to get to the episode or the captation, the transfer policy and some of this other stuff is really contradictory in terms of what we want to achieve if you step back and open the lens and look at the whole thing.

DR. ROWE: Just a couple things. I think this is very interesting. I think that the transfer stuff is getting more attention than it deserves. My colleagues in the hospital industry are going to hate to hear that, but I think the point is that this is only influences one-quarter of the people who are actually transferred, and of those you said 46 percent the change would be less than one per diem payment, and 80 percent less than two per diem payments.

So it's a relatively -- I think in the greater scheme of this set of issues that much more interesting to me at least from a policy point of view are the relative changes in the use of these other post-acute services. I think the '96 data are fascinating. '94 to '96 comparison is a little too close to really make --

MR. LISK: I wish we really had something that was earlier to describe more what had changed, but unfortunately we don't.

DR. ROWE: Let me just comment on Bill's point about the financial indifference. I think that it's interesting because, in my experience, the financial incentives are an important incentive and we try to drive behavior, you tried in previous commissions to drive behavior. But if they really have financial indifference, I think that what you're going to see is much more influence of patient preference.

I think that we need to realize that the financial incentives are one of several factors that determine when somebody leaves the hospital and where they go. Their physician input, the hospital administration input, but patient preference, particularly when it comes to going to a nursing home and which nursing home and which day they go is a very important factor. I think that maybe this is good to have financial indifference because maybe it empowers the patients and their families a little bit more, and maybe that's not all bad. So it would be interesting to see what happens with respect to that.

MR. LISK: That's a good point.

DR. KEMPER: One comment and then a question. In terms of the home health benefit, some of the earlier background material that you showed us made it very clear that the home health benefit is not simply a post-acute benefit.

MR. LISK: That's right.

DR. KEMPER: You mention that here, but I think it would be valuable to make that point a lot stronger here. Since that's where a lot of the growth is, that's where a lot of the issues are in terms of cost control, and maybe even digging out one of your earlier tables to show the magnitude of that. I don't think that applies to the other components.

But I guess the question I have is, you mentioned that this is really designed to provide background for future things. But I guess I'd be interested in your take-home messages, or at least maybe even some suggestion of either where you lead the Commission in terms of policy issues or suggest that we focus attention. Are there flags here in the data that we ought to be paying attention to? Or on the other hand, are there questions raised about why some of these things occur that ought to be investigated?

MR. LISK: One of the real flags that was raised to me was the frequency of use of the 18 percent of people who had a post-acute stay that were followed by use of another post-acute care provider. I think that may have real ramifications for how payment systems are designed for the individual post-acute care providers. Because if you go to the issue of a per case per stay, or per diem type of, or per service type of payment because it does show that there is a potential currently -- that there's currently also unbundling going on and a continuum of care going on with use of multiple types of post-acute care providers, and that could very well expand.

So I think that has ramifications for designing the payment system and what should be

done, or some sort of link. If you go with a per case system, the importance of some sort of link with that system if someone goes on to use some other type of post-acute care or the aspect of potentially bundling payments across all sorts of sites.

DR. KEMPER: Just one other more detailed thing is, you have immediate day use, first day use and then 30-day use. It seems like in the home health case the longer period is more relevant since I suspect there are a lot of people who get discharged who don't get home health right away.

MR. LISK: Right. The reason why we say the immediate is probably if the person had immediate -- if they needed immediate, it's likely that some of that care may be substituting for what would happen on the inpatient side. But if they get a break of a couple days, then they probably -- it may be related, but it's not directly related. It's other reasons why they're getting that service, because of therapy and stuff. But they don't necessarily need to be in the hospital -- in that case it's established and they didn't need to be in the hospital in that case.

So that's one of the reasons why we did the immediate and within one day.

DR. MYERS: I want to follow up on Jack's point. I like the idea of having financial indifference with respect to the push out of the hospital. But I'm not so sure we're able to ignore the possible pull from, especially the non-PPS hospitals that have really sprung up almost overnight with respect to trach and other ventilator patients. I'm wondering whether or not we could look at that with respect to density of those facilities and then lengths of stay.

It seemed to me rather interesting if we could figure out a way to create high density versus low density areas with respect to non-PPS beds, and then just determine how that seems to affect total cost and lengths of stay. I think that might be important for us to really understand as we begin to think through recommendations in this arena.

DR. ROWE: I think that's an interesting point, Woody, particularly given the fact that tracheostomy is on the top of that list, because there's probably --

MR. LISK: Basically, if you have the capability of handling a trach, some facility has the capability of handling that patient for ventilator support, there's no reason why that patient probably -- the length of stay in the inpatient side probably can be relatively short if that situation arises. Now clinically, I'm not a clinician so I can't specifically comment on that.

DR. CURRERI: Some proportion won't need ventilator support either. Some proportion just have tracheostomies without the ventilator support.

DR. ROWE: Right.

DR. WILENSKY: But I think the suggestion is a very good one about looking at density and seeing if --

DR. MYERS: And don't assume there's financial indifference across the board. The facility may have financial indifference, but in many of these situations, the providers in those facilities are in many cases the same providers as there are in the inpatient facilities. So the financial indifference may be only with respect to the facility itself.

MR. LISK: That's a very good idea.

DR. LAVE: You made a comment that was very clear in your statement here but was not very clear in the text, and it kind of addresses an issue that I was concerned about. That is that

when you were talking about Peter's 30-day and one-day, you commented that you really were interested in care that could be substituting for inpatient care, not these post-acute services, per se.

Let me tell you where I'm coming from. That is, as I think of my anecdotal information of friends, acquaintances, and relatives and so forth, when they have had -- most of them have had these things, they have gone home and then gone to hospital outpatient departments for rehab care. And there is no mention of the large outpatient rehab activity which I don't know where it substitutes for.

I think that if you feel that these patients need to be in a bed, which is what you are really saying, but that that bed can be provided in different settings, then these outpatients don't count. But if in fact somebody could be home and coming in, they should be there. So it might be useful when you're writing this chapter up to put up our famous continuum of care and try to plot out where you think people may sit. You could even do diagrams and show that you've got interactions.

But it would help put this whole complex of stuff, and why it is that we're so concerned with these things. Whereas, there are a lot of people who leave the hospital and go immediately into outpatient rehab.

MR. LISK: Right, and I did fail to mention that. That's another connection we want to explore more that we weren't capable of doing with this specific analysis, but we may try to connect with some subsample from the analysis file that we have in the future. Because we think that that's an important provider, and we suspect that in some of the high post-acute care use DRGs, which actually had a decline in use, that outpatient therapy has grown tremendously and that that may be one of the things that's happening is that outpatient therapy is being provided to some of those patients who are capable of getting to the outpatient facility.

DR. LAVE: So there is another question that links here, and the question is the following: Are you better off going to two inpatient facilities and an outpatient facility, or one inpatient and one outpatient? So you can do funny things with the reimbursement that looks as if you're saving inpatient dollars, but you really are extending the whole continuum. So I just think it's good to have an overview that pulls us into all of this so we know what piece we're looking at.

DR. ROWE: I think there are a couple distinctions here. One distinction, I think it's a little ambiguous as Judy said, talking about people who need a bed and go out of the hospital somewhere else. That's to be distinguished from people who previously used a bed, because previously the lengths of stay were longer and there were people who were using beds. They're now not using beds and they're getting care in other places. We shouldn't assume that those are people who needed a bed.

It may be -- and this is the second distinction -- that the relocation of those people is because now we have filled in this continuum of care that you're talking about. And it previously wasn't there so people didn't have access to the -- if you only have one or two spots along the continuum, then that's where everybody goes.

It may be that -- so one of the things in the overview that you might put in is not only the distinction between whether you used a bed versus needed one, but whether there was any place

else to put you. I think that the industry has changed a lot, particularly with respect to home health, so there are other places to put the patients.

And the last thing I'll say is that I think the growth, therefore, may be good. I think that one of the things in this commission we always say is that increase in volume, increase in use is bad. I think there's a question here, is it good or is it bad? In this case it may be good.

DR. KEMPER: Just going back to Judy's comment. I guess these figures mix the rehabilitation and therapy on the one hand and nursing services on the other?

MR. LISK: Correct.

DR. KEMPER: This is more type of provider, right?

MR. LISK: This is type of provider and we're not -- that's all part of additional future analyses and stuff when we get down to what's actually happening within those post-acute care settings. That's why I'm talking about, what we're talking about here is focused on the hospital because we haven't -- the only thing we're talking about is whether they used home health. We're not saying how much home health or what type of home health. And the same with what type of skilled nursing services they used and skilled nursing facilities.

DR. KEMPER: Is it possible to separate those two out, the therapy and rehab versus the nursing?

MR. LISK: In the home health side of things?

DR. KEMPER: No, across the board, across settings. I think the model is this morning's presentation where we try to look at the same service provided across settings. This is really looking at settings and mixing up the services.

MR. LISK: Right. It gets a lot more complex to do that type of analysis. I don't want to promise, but I think it is possible to do, but it gets extremely more complex. We'll probably be looking at some of this stuff by individual type of provider, and then we'll have to probably look at it that way and then bring it all back together and looking at what we see as the differences across the different types of providers. So we'll probably have to do it a provider at a time and then bring it back all together to see how it looks.

DR. KEMPER: I would urge you to go in the service direction to the extent that you can. I guess the other question for the report is, there's another chapter coming I guess that is about rehabilitation services, yet a lot of the rehabilitation services are here. So sort of a question of how they fit together. Not a small task.

DR. WILENSKY: Thank you.

Before we go to review of what -- let me ask if there are any public comments on the post-acute, this would be a good time to do it.

MS. WILLIAMS: Deborah Williams, American Hospital Association. Thanks, Craig, for a really excellent piece of work. It really was good.

One thing though I find puzzling though is the insistence that these inpatient hospital days are readily substitutable across all sites. If that's the case and they are, maybe we don't really have any need any more for hospital COPs, or all those thousands of pages of regulation that define home health as an intermittent level of care.

If home health is the same as SNF, which is the same as rehab, which is the same thing as

inpatient care, why bother to have it? Or all those rules that say, for instance, that you can't transfer a patient out of the inpatient setting unless they haven't had a temperature for so many hours? They must all be moot. It's all the same, right?

DR. ROWE: Is that an essay or a multiple choice?

[Laughter.]

DR. WILENSKY: Stu?

MR. GUTERMAN: The purpose of this presentation is just to have a brief discussion of our plans for the other part of our work in the next couple of months. The day started with an analogy about a trip on a boat, and I tried to come up with one that applied to this and the best I could come up with was the SS Minnow from Gilligan's Island; but this won't take long.

DR. NEWHOUSE: You haven't heard all our questions yet.

MR. GUTERMAN: The Balanced Budget Act of 1997 requires the Commission to report in its June report on non-payment issues and on the relationship between the Medicare program and the American health care system. Over the rest of this meeting and the next meeting in April you'll be hearing all the papers that we're planning to put in our June report.

We've separated out a piece of the work of the predecessor commissions that people on the Hill found useful and we found useful to monitor but this is more of an availability of trend and baseline information for evaluating some of the policy options that get discussed throughout the year, and we've decided to put them into a separate volume that we hope to get done in the first half of July.

Since I was the one who put together the overhead, I refer to it as health care spending payments and utilization. It's been referred to as the chart book or trends. But it's not really trends. I think it's more a report on health care spending payments and utilization under different headings.

This is a work in progress. Our thinking is just getting pulled together on this since we've been so distracted by first the March report and then the June report now. But our thinking is -- and this is what I want to review here and get your reaction to. Our thinking is that we would have at least six headings. Actually, I've added one. If you want to squeeze between post-acute care and physician services, squeeze in ambulatory care, I think we'll have enough for a separate section on that. I can go through each of these bullets and talk a little about what's going to be in them.

The first heading is national health care spending. Here we would use data that's developed by HCFA primarily and attach data from CBO where appropriate, to look at trends in national health spending, look at the components of health spending and how that's changed over time. That is, the different types of services and how much is being spent on each. And also an analysis of the sources of national health spending, the different payers that contribute to paying for the health care that the American people receive.

We also could include, and somewhere in the report probably will include, an analysis of Medicare spending and the growth in the various components of Medicare spending here. There's also a section which I'll refer to as the interaction of payers -- people tend to refer to it as cost shifting analysis or payer's analysis -- that at an aggregate level will look at trends in Medicare,

Medicaid, private payer, and uncompensated care payments to hospitals which comes from our annual analysis of the data from the American Hospital Association.

That sets the stage and connects Medicare with the rest of the American health care system. Then we'll focus on different sets of services or providers. We have an analysis of hospital cost payments and financial condition that should say, that is our usual analysis of the trends in hospital costs, which as you know have been extremely low lately, the distribution of payments and the components of Medicare payments across hospital groups and areas, and an update on hospitals' financial condition. And we will, as Gail said this morning, have data for 1996. We will have that in time for this report. We wouldn't have had it in time for inclusion in the June report.

DR. MYERS: When you look at hospitals, are you going to look at them in a sense by license or by governance? Because I think this whole question of integrated delivery systems now causes me to believe that a look specifically at hospitals by license may not give us the complete picture. How do you intend to --

MR. GUTERMAN: What we've generally done is when we look at -- we tend to look at both PPS inpatient margins, which focuses on the Medicare inpatient part of it, and on total margin is what the hospital itself, the entity reports as all of the revenues and expenses for the financial entity. That is, the entity that's included on the worksheet G of the cost report. So that should include subproviders and all of that.

DR. MYERS: So that's yes.

MR. GUTERMAN: We'll also in this chapter have an analysis of payments and cost by payer by group of hospitals, which corresponds to the aggregated analysis that would be in the previous section or chapter, which will indicate what changes have occurred in the relative financial pressure coming from each of the major payer groups and how that plays out across different groups of hospitals.

We'll also have a section on post-acute care where we review the proliferation of providers that provide this case. We'll review patterns of utilization, both across types of providers and geographically. And we'll look at the growth in Medicare payments for these services to sort of provide a baseline for the systems that are going to come into place over the next couple of years.

DR. ROWE: Stuart, would it be possible to consider a change in taxonomy? I'm just relating to what I've heard today and thinking about this a little bit -- to something like continuum of care instead of post-acute care?

I'm trying to think about what we've been talking about, what Judy and Spencer said earlier. Because post-acute, it refers to more the location than it does the patient's need. It suggests that the acute phase of the patient's problem is over. In fact it may not be, it's just that they don't happen to have to be in a hospital during that. They still might be acutely ill by their definition of what they're able to do or not.

What we're trying to do is --

DR. NEWHOUSE: What about post-hospital care?

MR. GUTERMAN: Except home health isn't necessarily post-hospital.

DR. ROWE: I'll try this again another time. I don't sense a lot of enthusiasm for this. But I think at some point we have to think about-- it's the emerging continuum of care, or something --

MR. GUTERMAN: I think that's an issue that can be addressed throughout. I think really the continuum of care is everything that you have there connected. It's ambulatory care, physician services, what we call post-acute care, and hospital care. We can reflect awareness that all of these things are connected. In fact, that's what the data tend to --

DR. ROWE: Instead of post-hospital, which implies a relationship in time, it might be like out-of-hospital care, which could be before or after or whatever.

DR. CURRERI: Now how do you separate that though from ambulatory care? That's out-of-hospital.

MR. GUTERMAN: Or physician.

DR. CURRERI: Or physician offices, whatever.

DR. ROWE: That's included in it as well as nursing home.

DR. KEMPER: I'm not sure about the terminology, but the thrust of the comment I agree with.

MR. GUTERMAN: We can certainly have the tone of the report reflect that.

DR. KEMPER: We don't have language for it, but it's neither post-acute nor post-hospital exclusively.

DR. CURRERI: Stuart, under the hospital section, is that where disproportionate share and those kinds of things will be, particularly -- what do you call the hospitals in the rural areas?

MR. GUTERMAN: Sole community hospitals. We can focus -- those will be among the hospitals we focus on. We're trying to keep this volume pretty slim because we'll be turning to it at the same time that we're still working on the June report, with an eye toward next year maybe being able to incorporate it all into a more cohesive package and broader considerations. We certainly won't be ignoring disproportionate share issues.

DR. LONG: Stuart, when you talk about 1996 data, are we talking PPS years or calendar years?

MR. GUTERMAN: That's right, PPS 1996, which actually overlaps fiscal year 1996 and 1997.

We'll also have a section with some data on ambulatory care that we're developing, some of which we'll plan on having in our response to the hospital OPD reg which you'll see. But we'll try to assemble data on hospital outpatient payments and costs and some other data that describes trends in utilization. I can't see if Jim has a shocked look on his face as I mention this, but I hope it's okay with him.

Physician services, we'll also be portraying the distribution of providers, the patterns of utilization of physician services, and as much as we can, setting a baseline describing the distribution of payments and the components of payments to physicians.

DR. CURRERI: How about non-physician services?

MR. GUTERMAN: We'll see what we have.

DR. HAYES: You're thinking about psychologists, chiropractors, and nurse

practitioners?

DR. CURRERI: Nurse practitioners, physician's assistants.

DR. HAYES: We can do that. That's fine.

DR. CURRERI: If you don't, you're going to hear about it from those groups. Just maybe one or two.

MR. GUTERMAN: We'll be putting together a more detailed outline and have you review it.

We also can have a section of graduate medical education which addresses workforce and payment issues, just pulling together and updating the data that you've seen over the years in those areas. We'll be also developing our workplan, which you'll see at your retreat, for the graduate medical education work over the next year-and-a-half.

Then we will be pulling together data on -- actually Medicare risk program may or may not be a good title for this. It can't be Medicare+Choice because we won't have any data really on Medicare+Choice yet, but it will sort of be providing a baseline set of analyses to describe the lay of the land as Medicare+Choice develops with analyses of enrollment data and payment data and plan participation, and we'll focus on the variation in those levels and the distribution across areas.

So that's pretty much it. We'll be glad to take input as to suggestions about information that you or your constituencies or people that are interested would want to see in a volume like this. So basically it would be viewed as the kind of volume that an interested party could just pull off the shelf and look at the information that they want to see about each of these areas.

DR. NEWHOUSE: I'll give you three items. One is a number I stumbled across that's out there. We've always talked about the risk program -- we being both of the predecessor commissions -- in terms of enrollment. And what I stumbled across was actually spending in the risk program is actually a lot less than enrollment, largely because of the age adjustment effect in the formula.

So when we're doing spending if you could do the risk program dollars by type. That is, coordinated care, private fee-for-service, and MSAs as they come on stream, in addition to enrollment, I think that would be useful.

Then a number that I have trouble finding that I don't think I should have trouble finding is if I could have a breakdown of Part A and Part B spending by provider type, and actually over time.

I see Tom Bradley is sitting out there, but I also have trouble keeping up with CBO forecasts. So if you could just, when you do -- you mentioned the trends. If you just put in the most recent CBO forecast that might be helpful in disseminating their number.

DR. LONG: Stuart, do you have any influence with the powers that be over the timeliness of the generation of things like national health expenditure data? A very few weeks ago we actually were treated to the 1996 information at roughly the same point in time that most other organizations in the real world were reporting 1997. It seems to me that a 14-month lag is not very reasonable. I don't know when we plan to go to press with all of this and we probably won't have 1997, but maybe if we didn't have to wait 14 months for that kind of information it would be nice.

MR. GUTERMAN: CBO can give us 2005.

[Laughter.]

DR. NEWHOUSE: The trustees can go even further.

DR. LONG: Are we going to summarize anything out of the trustee's reports which are due out in about a month?

DR. WILENSKY: It's actually due out April 28th.

MR. GUTERMAN: It wasn't on the list but we certainly could consider it, and we certainly could discuss it at least in the discussion of national health care spending and Medicare program spending.

DR. WILENSKY: Any other comments?

Thank you. We are finished for today.

[Whereupon, at 4:34 p.m., the meeting recessed, to reconvene at 9:00 a.m., Friday, April 10, 1998.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Friday, April 10, 1998

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.

The meeting in the above-entitled matter convened, pursuant to notice at 9:01 a.m.

COMMISSIONERS PRESENT:

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
P. WILLIAM CURRERI, M.D.
ANNE JACKSON
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH LAVE, Ph.D.
DONALD THEODORE LEWERS, M.D.
HUGH W. LONG, Ph.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, M.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA

P R O C E E D I N G S

DR. NEWHOUSE: Why don't we come to order.

Our first topic this morning will be access to care, Kevin Hayes.

DR. HAYES: Good morning. First, I have to start with an apology. I'm sorry about the photocopying of this chapter. I hope everyone ended up getting a complete copy of the chapter, with tables and figures included and so on. Is that true? Everybody's all right?

Let me just say a couple of things about how we went about putting together this chapter. There were two considerations in mind whenever we put it together. The first was that this would be the first time that the Commission had an opportunity to really focus on access issues. Access has come up from time to time in discussion, as it did yesterday, in connection with physician payment rates and other issues, but this is our first chance to really look at access with some care.

The other consideration was that we recognize that access is a multi-dimensional concept. It means different things to different people. And so what we tried to do here was just cover as many different access issues as we could and hope that at least some of them would reflect your interests.

We did that by doing two things. We reviewed the work that both of the predecessor commissions did in this area. And secondly, we looked at the most recently released data from the Medicare current beneficiary survey to provide us with an overall perspective on how beneficiaries perceive their access. And we felt that by doing those two things, we would cover a lot of territory and we look forward to getting your comments on what we did.

We've got, of course, a work plan at the back of the chapter which we'll talk about and see where we want to go with this topic.

As I said, access is a multi-dimensional concept. For some it involves issues of availability of services. Payment rates are important here, availability of providers, organization of services, and a whole host of beneficiary socioeconomic factors, I guess we could say.

The concept has been defined in a number of different ways and we provide you with some alternative definitions in the chapter.

Researchers who focus on this issue tend to start with some kind of a conceptual model of how they feel access works, what things are related to access, how it can be measured, and generally what that boils down to is we end up with some various measures on the process of care and outcomes of care. And by looking at those different measures we try to draw some conclusions about whether or not there are access problems, whether or not access is changing over time, and so on.

I'm going to skip over all of what we said in the chapter about the previous work of the predecessor commissions. I really couldn't figure out a good way to summarize that in just a few seconds, and I hope you don't mind, but I'm sure you read what was in the chapter. So we'll just focus on what we said about data from the Medicare current beneficiary survey.

This survey is administered by HCFA's Office of Strategic Planning. In 1996, over 16,000 beneficiaries living in a community were interviewed for this survey, and it's a nice took for

monitoring access to care because it includes a number of questions about problems beneficiaries have obtaining care, their satisfaction with care, and so on. Of course, it tells us a lot about their characteristics, income, and so on, education, a variety of factors. So it's a real nice tool.

Starting in 1996, the MCBS became much more useful for monitoring access in managed care. With the 1996 survey, managed care enrollees were oversampled such that we have data on over 3,000 managed care enrollees for 1996.

Also, the survey included a number of questions specific to managed care. It asked questions about problems beneficiaries had obtaining referrals, benefits offered by their plans, reasons they had enrolled, and so on.

In addition, there were a number of questions -- all of the questions that were asked of the fee-for-service enrollees were asked to the managed care enrollees, also, so it's real handy for making comparisons between fee-for-service and managed care.

If we focus first on what we see with respect to fee-for-service, we find that overall beneficiaries report good access to care. Only 3 percent of them report trouble obtaining care. 96 percent of them were very satisfied or satisfied with the overall quality of care that they receive.

We do see that some vulnerable groups of beneficiaries report more problems than others. For example, those saying that they're in fair or poor health, of those, 16 percent also report delay in care due to cost. That percentage would be compared to 4 percent of those reporting excellent health and 6 percent for those reporting good or very good health.

For those who have no supplemental coverage in additional to Medicare, they are not dually eligible for Medicare and Medicaid, they don't have private supplemental coverage. Of those, 28 percent say that they lack a physician or physician's office as a usual source of care. That compares to 8 percent for those with private supplemental coverage and 17 percent among dual eligibles.

If we now look at just how fee-for-service and managed care compare in the MCBS, it really depends upon the question that beneficiaries were asked. With respect to having trouble getting care, the fee-for-service enrollees tend to report better access. Only 3.1 percent of them say that they had trouble obtaining care, whereas 5.3 percent of the managed care enrollees said they had trouble.

On other questions, though, it looks like managed care comes out of it better. With respect to delaying care due to cost, we see that only 5 percent of managed care enrollees report such delays, whereas 8.5 percent of the fee-for-service enrollees overall say that they have experienced this problem.

Similarly, on lacking a physician or physician's offices as a usual source of care, we have 7.7 percent of the managed care enrollees saying they have this problem, whereas 11.7 percent of the fee-for-service enrollees say so.

With respect to satisfaction with the availability of care on evenings and weekends, the managed care enrollees come out of it better there, as well. 24.1 percent of them are very satisfied with that availability, compared to 19.8 percent for the fee-for-service enrollees?

DR. ROWE: Kevin, how does that relate to -- it's so bad I thought maybe you were really

saying like 76 percent versus 80. What you have here is the earlier number that suggests that 96 percent are very satisfied or satisfied with quality of care. Now we're down to 24 percent. This is because it's only very satisfied and it's only nights and weekends and the middle of holidays or something like this?

DR. HAYES: What we focus on is the very satisfied measures being one that's more sensitive, we feel, to beneficiary access issues. So we could do a similar comparison combining the very satisfieds and satisfieds. But in these types of analyses we traditionally just pulled out the very satisfieds and made a comparison.

DR. ROWE: How does this number -- as somebody who's an expert in the field, how does this number strike you? Does this the sort of number you would expect to see in a commercial population or a non-Medicare beneficiary population? I just have no idea.

DR. HAYES: I don't either, to be honest with you. One of the things that we talk about in the work plan is using the medical expenditure panel survey that AHCPR has put together to do those kinds of comparisons, comparing Medicare beneficiaries with those not yet eligible.

MS. ROSENBLATT: Just to pick up on Jack's point, typically in the commercial environment you would combine the dissatisfied and the very satisfied, so you'd be looking at number like 80-some-odd percent.

DR. HAYES: If we just look briefly at the questions that were focused on the managed care enrollees, we find that beneficiaries cite two reasons as being their most important reasons for joining their current plan. One is lower cost, and the other is better benefits. Managed care enrollees also identify some particular problems they have. 8 percent of them say that they've had some difficulty obtaining referrals to specialists. A small percentage, 2 percent, say that their plan has refused to pay for emergency care that they received.

When we take these responses and combine them with what we see in our comparison between fee-for-service and managed care one conclusion one might reach is that it looks like managed care enrollees are, in a way, making some tradeoffs. They do report a slightly higher level of problems obtaining care. They cite some particular problems that they're having here, but on the other hand they do see managed care as attractive in terms of lower costs, better benefits, higher satisfaction with the availability of care evenings and weekends, more likely to have a physician or a particular office that they can identify as the usual source of care, and so on.

It would be nice to go beyond just these beneficiary reports about access and to get at some more clinical issues and we have some ways that we would like to do that, and that's the kind of thing that we've addressed in this work plan.

First, Andy would just like to talk about a couple of new surveys that are coming online that will make some data available to us for purposes of monitoring access.

MR. COSGROVE: Thank you, Kevin. That was a wonderful job despite being sick all week.

I'm just going to say a few words about some of these surveys. These three surveys you see listed up there were mandated to be collected as part of the Balanced Budget Act. The primary intent of these surveys was to compile summary information to facilitate choice of choosing plans for beneficiaries. But the disaggregated data from some of these instruments

should prove useful for analyses of beneficiary access.

The Consumer Assessment of Health Plan Survey of CAHPS, there's a special Medicare version of that that will assess the satisfaction of Medicare+Choice beneficiaries with their plans. Approved contractors will administer
a customized version of this to 600 members of each plan
in 1998 and annually thereafter. CAHPS will collect detailed information on access and self-reported health status at the beneficiary level. However, the nature of some of these questions may make comparisons across small groups difficult. Nevertheless, the CAHPS should provide a sizeable bank of information on beneficiary health status and the perceptions of beneficiaries with their access to care.

HEDIS, which I'm sure many are familiar with, the Health Plan Employer Data Information Set, this is, as you know, originally to gauge employer based health insurance. But there is a special Medicare model. HEDIS measures the quality of a plan along a number of dimensions, including access to care.

HCFA directed that Medicare+Choice plans, at their expense, report the special Medicare version of HEDIS beginning in 1997. NCQA, who developed HEDIS, NCQA approved auditors will verify the data from the 1998 round of data collection.

Although some of the 30 measures in the latest version of the Medicare HEDIS are reported at the beneficiary level, most of these measures, including the measures for access to care, are reported at the plan level only. Nevertheless, some of this data may prove useful in making plan level or regional comparisons.

The third one listed up there, the Health of Seniors survey, that will be administered in 1998 to 1,000 members of each Medicare+Choice plan. It will gauge in detail, at the person level, the health status of cohorts of Medicare beneficiaries at two year intervals. HCFA plans to release data from this survey after the year 2000 follow of the first cohort.

The health status data from the HOS may be useful to the Commission to link with some of these other pieces of data and counter data enrollment data for thorough measurement of clinically based access.

DR. LAVE: Andy, can you tell us a little bit more about what this instrument is? This is the first time that I've heard of this one.

MR. COSGROVE: The Health of Seniors? It's going to gauge in detail, I have a copy of some of the questionnaires I can get to you.

DR. LAVE: If you could send each of these, that would be great.

MR. COSGROVE: Yes, I can absolutely do that. One of the main features is it asks the 1,000 per plan in 1998, it goes back to the very same people in the year 2000 to see if there maybe is a change in the health status.

DR. MYERS: Is it self-administered?

MR. COSGROVE: No. I think it's a survey like on the phone or through -- I'll have to check. There may be mail versions, mail-in versions, but I'll definitely check that out.

DR. CURRERI: I'd like to ask a question. This data is very good but here we are in April of 1998, retrospectively looking at 1996 responses, and I suspect a whole lot of things have

happened between 1996 and 1998, and we won't look at 1997 data it's my understanding until probably January of next year. So we've got about a two year hiatus.

Now suppose we detect a problem. It will take another year to try and figure out how to fix it. Are any of these things designed prospectively to look for potential hot flags or something? All of these seem to look back at data and look back a fairly long distance by the time they get analyzed and so forth.

I just wonder, are there any kind of prospective surveys going out that says we think there may be a problem developing in Wyoming and maybe we ought to look at this? It seems to me we have an obligation to do something like that, particularly with the rapid changes that are going to be coming up.

DR. HAYES: Bill, are you talking about these particular surveys of managed care, or are you talking about access in general?

DR. CURRERI: I'm talking about access in general.

DR. LAVE: Early warning signals.

DR. CURRERI: Yes, how do we identify a hot spot?

DR. NEWHOUSE: If the cardiac surgeons in Wyoming decided they weren't going to accept Medicare patients, how would we find out?

DR. CURRERI: I think that there used to be -- we had some things that we did before like surveying Congressman and Senators office staffs and like using AARP, for instance, as a sounding board for potential problems that at least we could keep our eye on. All of these are looking way back in data. By the time we find some real problem, it's going to be a problem for a couple of years.

DR. NEWHOUSE: Maybe we should hold the general discussion until they get through and we'll come back and start off with this point.

DR. HAYES: Let me just make a couple points about this encounter enrollment data item on this overhead. The PPRC did a lot of work with what we called clinically based indicators of access, and the hope is with encounter data for managed care plans, we would be able to do the same kind of thing.

As you know, HCFA has the authority to collect encounter data. They've been given that authority under the BBA. It's far from clear at this point when the data will become available for anything like this, but we did at least want to point out that there is that potential to look at use of specific services by those who have particular health conditions. That's the promise that that encounter data holds for us with respect to monitoring access.

With respect to enrollment data, it's possible to calculate disenrollment rates for managed care in general for individual plans, and to use those disenrollment rates as indicators of satisfaction with managed care. We are working on an analysis now with beneficiary enrollment files, and could have a short paper for you on that subject for the next meeting. But in any case, that's the kind of thing that we would propose to use to augment our monitoring access in Medicare+Choice plans.

Going to the next and final overhead, we do have some thoughts about how to monitor access in fee-for-service. The main issue here has to do with changes in payment methods. As

we discussed yesterday, we're looking at use of a single conversion factor this year, which has had an effect on physician payment rates, implementation of resource based practice expense relative values starting
in 1999, prospective payment systems for OPD, SNFs, home health, rehab hospitals, and so on.

And all these areas have some potential for access problems, and what we propose in the chapter is using episodes of care as a kind of analytical framework and to look at how the content of episodes of care are changing over time. In an ideal world, we'll also be able to look at how outcomes of these different episodes are changing over time, and that would give us a pretty good handle on what's going on with access.

In our general discussion, I have a feeling we're going to be talking about some other things along that line, but I'll stop with that.

Also in the area, particularly in fee-for-service, but I think it's kind of more general, having to do both with managed care and fee-for-service, we also have some ideas about how we can look at access for beneficiaries living in rural areas. Louisa has given some thoughts to that and she would like to address that.

MS. BUATTI: We're considering a couple of projects focused specifically on beneficiaries in rural areas because we think that the health care organization in rural areas is likely to change in the next coming years. And there's still concern about access to care in general in rural areas, and specifically access to managed care.

The projects we're considering are both at the facility level and the beneficiary level. The first project that we're thinking of involves gathering descriptive information about the health care infrastructure in the non-metropolitan areas. In this analysis, we'd look at the number and distribution of different providers, as well as characteristics of the areas in which they're located.

The beneficiary level analysis we're thinking about right now would be to determine where beneficiaries who live in rural areas actually receive their care. Whether rural residents receive care locally or have to travel long distance to either urban or other rural areas to get care will provide us with some insight about their ability to access health care.

In conducting that analysis, we would identify a group of rural residents and analyze their claims data. This would give us better insight into their needs and then would also help us determine how providers located in rural areas might better organize themselves to meet those needs.

In addition, we could then compare the mix and numbers of services received by rural residents with their urban counterparts. Also, it would be possible to look at the appropriateness of care of rural residents using the outcomes based approach that Kevin mentioned earlier.

Then finally, our fourth project would involve analyzing the financial condition of hospitals in rural areas. We still think that these are important providers in rural areas and that their financial viability might have some impact on access.

So that's what we're thinking of now and we welcome your suggestions.

DR. NEWHOUSE: I want to come back to Bill. Let's start on the discussion we kind of started, that we needed a monitoring system, which I think is where Bill was coming from. And what is that? Now we need to put some flesh on the skeleton of what that means.

DR. CURRERI: I really don't have any more to say. My only concern is that if we're running on a cycle of examining this that's two years after the fact, that there's going to be a lot of potential difficulty for the beneficiary before such time as corrective steps can be taken.

It seems to me even if it isn't strict analysis and we haven't got all the data, we should have some sort of a prospective survey mechanism, however it is. I don't really mean to say survey, but some sort of a mechanism that we can identify where trouble is perhaps arising, and we can focus our attention on it or get preliminary data or do a site visit or something, is what I'm really getting at, rather than depending on this time lag which is necessary because of the time required to collect data.

DR. NEWHOUSE: I guess the other question is, if we don't do this ourselves, or even if we do, what plans HCFA has along these lines? Because they must have similar kinds of concerns. Do we know? We can find out.

DR. HAYES: No, we know. The problem is that HCFA has the same responsibility we have to monitor access.

DR. NEWHOUSE: That's why I thought I would have thought they would have had similar concerns.

DR. HAYES: We also know that the last report that HCFA issued on access to care was for 1995. So I think that it's fine for this group to recommend to HCFA that they monitor access, as they are required to do, but I think we need to have -- that's fine as a fall-back position, but I think we need to make sure that we can monitor access ourselves.

DR. NEWHOUSE: That's fine. It's just that we need to know what HCFA is doing.

DR. HAYES: Can I respond to Bill's thought? When the fee schedule was first introduced, you know that we did work hard to try to set up such an early warning system. What we did was to get claims data from the first six months of a year when a major payment change had taken place, and we were able to analyze those data at the end of that year.

So in the case of the single conversion factor, which has been implemented this year, in 1998, by December of this year we will have claims data in hand that will tell us about what's happened to use of services on a per beneficiary basis by type of service, comparing say the first six months of 1998 with the first six months of 1997. To me, that would be a good quick way to look at what's going on with access to care.

As we looked at those numbers over the years at PPRC, the concern that developed was that built into those numbers was a certain amount of unnecessary use of services. That's why we started to gravitate more and more toward those clinically based indicators of access, because there we had some more assurance that we were looking at changes in use of truly needed services.

What I think I'm hearing now is that well, that's fine, we should use the clinically based indicators of access as kind of a gold standard, but for purposes of things like the single conversion factor which was implemented this year it's a dramatic enough change in payment rates that we really do need to make sure that we look closely at those changes in use of services, as at least a preliminary look at what's going on.

DR. CURRERI: I think that's right. I think it needs to be looked at at a regional level and

in a variety of different ways to see if we can -- because my hunch is that if there are access problems it's not going to be a national thing. It's going to pop up here and pop up there, and that there are a lot of local factors involved in this, and there's differences in providers philosophies about dealing with the insurance system and so forth.

So I was hoping for some way that red flags can go up when there's potential problems.

DR. MYERS: This is not the first time that we've heard this issue brought up at this meeting. In fact, I can't think of a meeting that I've attended in this commission where this timeliness of data issue hasn't been brought up. It's very clear that the BBA asks us to do this. It's very clear that other Federal agencies have this as a mandate and as an interest, as well.

I'm wondering, Joe, whether or not we ought to consider taking a more proactive step in the sense of perhaps even asking the Secretary or the assistant secretary to find a way for us and other agencies of government to have a more early warning system on access and the other relevant questions brought up within the BBA.

We're not going to destroy the current data collection structures that exist nor is it, I think, our goal to try to do that. But they're just not timely for us with respect to answering the questions that we're being asked to answer. Either we will do as Louisa's proposed and create our own set of studies that seem to meet some of our needs, or perhaps heaven forbid we get together with others who have the same interest and try and do it in a coordinated fashion that serves all of our needs.

I don't want to dismiss that more complicated task out of hand. I just wonder whether or not we ought to at least attempt to see if there's interest in creating a more comprehensive early warning system on access and other related issues that serves the needs of not just MedPAC but other agencies of government who want to get this information and who need it under their mandates in law and regulation.

I'm really asking the question, given your knowledge base and experience on this issue, whether or not you think the time has come whether this Secretary and assistant secretary might consider doing something along those lines that will clearly help us? And if we don't ask today, we're not going to have it in time for us to be able to use it when we're required to.

DR. NEWHOUSE: I think it goes to -- Kevin may want to say something -- goes to the collection of data. Once the data are in hand, just as the surveys are here, we can analyze the data. I don't think we would want the analysis part to be joint. Then we come to how fast the claims data or other data that we're relying on are processed and made available to us. I guess we can try to work on that.

DR. MYERS: There are private sector entities that get this data virtually on a real time basis.

DR. NEWHOUSE: They don't get Medicare claims data.

DR. MYERS: No, real time meaning very close to the time that the care has been provided, as opposed to waiting a year-and-a-half, as we seem to be doing today. And not that we have to have 100 percent. Couldn't we just have a statistically valid sample that's regionally appropriate?

DR. HAYES: I think we can do a lot with the claims data that I was describing. This is a

5 percent sample of beneficiaries. We're talking about 1.7 million beneficiaries for whom we have claims data. We can do some regional estimates. I'd say we can probably do some state level estimates.

The challenge comes in figuring out what areas we want to look at. Where do we think there are hot spots? In the past, we have just gathered together whatever anecdotes we could. We've collaborated with beneficiary service organizations on surveys in such areas. We've contacted, as Bill said, Congressional offices and asked them about where they're hearing about complaints to access.

The problem you run into then is how systematic is that information? You're still building on anecdotes.

I like the idea of just using the 5 percent sample of claims data and figuring that we can look at quite a few different areas but we're not going to get 100 percent coverage of the entire U.S. and all geographic areas within the U.S.

MR. MacBAIN: Just a couple of other concerns with claims data, and that's there are other variables you need to control for, particularly if you're looking at a short time period, such as weather or outbreaks or infectious disease, but particularly now with Medicare+Choice. And particularly, if you try to get down to a regional level, you could have a large gap in claims data in year two versus year one, simply reflecting unusual success of Medicare+Choice plans.

So looking at that, remember that there are other significant variables in there that it's going to be hard to control.

The kind of thing I think Bill is getting at is are there ways that we can tap beneficiary perceptions of access, which may be more important than what's actually reflected in the claims data. Do people feel that they're having trouble getting to the care that they want to get to? And is that appropriate or inappropriate?

If they can no longer get routine care in an emergency room, maybe that's okay. Maybe that's something we wanted to happen. But we ought to measure to that and find out.

But it's a different data source, I think, than claims. Whether it's complaints or surveys or -- that's probably about the only other sources. There is also less of a lag in that kind of reporting, depending on how it's designed, as opposed to trying to deal with claim data.

DR. HAYES: The MCBS is pretty good. The access supplement to the MCBS comes out about a year after it's been fielded. So we would have, by early winter of this year, we would have 1997 survey data from the MCBS.

MR. MacBAIN: In a competitive business that would not be an acceptable turn around time for a marketing survey at all.

MS. ROSENBLATT: I'm just wondering if it's possible to look at the way benefits consultants who are doing work for employers judge networks and use that to look at what's going on with access. One of the things that these benefits consultants do when they're looking at a managed care plan is they ask questions like how many providers have left the network. I just learned from Jack that there is a notification requirement for physicians who no longer participate in Medicare.

So if there was a way to monitor the number of physicians that are terminating

participation and where those were occurring, that might be an early warning.

The other thing that's used is -- this is a particular and there's probably more than one. The one that I'm familiar with is a vendor called Geo Access. Geo Access actually maps -- you set a parameter like within five or six miles there's a primary care physician and you can also set parameters for specialists. And again, if you view the Medicare participation as a network of providers, you can then track things like that using software like that.

DR. LAVE: I guess the question that I have is how big do we think this effect is? If you were interested in trying to get sort of an immediate sort of feedback, you know, you wonder why you can't use like a Harris polling system with the beneficiary lists that would have about 10 questions that would be highly targeted.

I mean, the CAHPS is a very interesting proposal but it is extraordinarily long. I've seen an early version. It is very long and it picks up all kinds of information about -- and it picks up much more information than probably anybody will ever use in any analyses of those data.

But if you really were interested in trying to find out whether or not there seems to be a significant change in access to care and one could, if you were concerned about geographic region, it does seem to me you could do something like that and it probably would not be too expensive because we could use the Medicare mailing list to identify the correct group of people that you, in fact, were looking at. If you interested in rural folks, you would contact rural people.

It does seem to me that there is something that you could do that is shorter, quicker, more targeted and more directed to picking up whether or not there's a major issue that's developing out there.

DR. KEMPER: Just a quick comment. It sounds to me like we ought to have a two-pronged strategy. One is the early warning, but somewhat imperfect kinds of indicators. But then maintain the longer term, you know, claims and current beneficiary surveys so that we maintain that longer run, but obviously more delayed kind of information.

DR. NEWHOUSE: How much support would there be among the commissioners for potentially using some of our contracting money for the kind of thing Judy was suggesting or others? Sort of general assent to that idea.

DR. HAYES: Can I ask a question? Peter, you said a two-pronged strategy. It would seem to me like there needs to be a three-pronged strategy here.

Bill pointed out yesterday that we anticipated there may be some access problems developing. And then the question was asked of Bill Scanlon and Terry Kay what do you do about that? What if you do find that there are particular areas that have problems?

So it would seem like, parallel with our efforts to monitor access, we need to do some kind of a think piece on what to do.

DR. NEWHOUSE: Amen.

DR. LEWERS: There are two or three points that I'd like to make. One of the points that I see when I saw the list of the surveys, there's one very important group missing and that's physicians and other providers. We've ignored them.

Now HCFA can give you very gross data which is late data on physicians who participate. But as I've traveled this country, and I do so extensively, I hear more and more physicians telling

me I've stopped seeing Medicare patients.

Now I can't pick a trend. I can give you pockets. I can give you a couple of states where that's happened.

And it's not related to the private contracting debate that's going on on the Hill, not at all. But it's the frustrations, it's the harassment, it's just general frustrations.

But there are other areas that I think we're missing because physicians are telling me they're having to let their staffs go in their offices, so they do not have the staff to provide the services they have in the past. They're doing points where they're having to increase numbers of patients in less time.

These are access problems which I think, as our example yesterday of the iceberg, this is the tip. And I think this is going to give us an early warning sign.

So number one I think that somehow, and I don't know how you're going to fit it in, you should be surveying physicians and not just saying, you know, are you a participating physician or are you not a participating physician?

The other thing, in some of the other surveys, I think again -- and I know time and I know the claims problems -- we're looking at a tip there, as well. For instance, say the 28 percent of lack of physician or physician office as the usual source of care. Why? Because the majority of patients that do not have a physician do so voluntarily until they get ill.

And so you've got to take a look at where are those 28 percent? Who are they? And for instance, say also that they have a higher satisfaction with availability of managed care. Why? Is that related to cost? Is that the fact that it's a no paperwork? Is it the fact that I can walk in and I don't have to put a down payment down for my services?

So I think that we need to try to look at our questionnaire and make sure that they fit.

I had a question on rural services, an area that interests me. In the paper, and I don't know which of you wrote it, it talks about rural patients are more apt to be hospitalized without going through emergency services or for services that, in general, would not be hospitalized in an urban area. Is that because of the distance they live from the facility? Is that because of lack of facilities elsewhere? I don't know why they do that.

I think we have another opportunity here to take a look, particularly at plans and at managed care plans, because in '99 we're going to see a change in geographic reimbursement to the plans where in a rural area now the plan reimbursement is rock bottom and now we're going to slowly, hopefully bring that up.

So I think we have an opportunity to see whether that is an element that has contributed to the lack of access to managed care, for instance, than it is just a lack of access to total care. I don't know how you survey that, but I think that's an area that we have some data now but I think very quickly we could get that data, probably by the end of '99.

DR. NEWHOUSE: Ted, let me follow up on your first point. Is the AMA survey capable of doing anything along these lines?

DR. LEWERS: We have begun to look and see if we can find some point, yes, but it is early. But I think it needs to be part of what we're doing, as well.

DR. CURRERI: As a matter of fact, in the past we have had a Harris poll of physicians at

one time and we had another -- I've forgotten who the polling agency was. But I think you're right. Also, you have to make sure you're asking the right questions on those polls. Not just whether you participate or don't participate, because the vast majority of people do and so you're not going to get much data there. You really have to look at what their reaction is to whatever is doing on at the present time.

DR. LEWERS: As you know, the AMA does surveys constantly, but our SMS data would not pick that up in all probability. But we do other surveys on access, but they're minimal as far as the data I think we need.

DR. ROWE: Thank you, Joe.

I had three points. The first has to do with you have a comment about vulnerable populations which I think are very important and we're going to hear more about that in the next presentation. But most of that has to do with enrollment and Medicare+Choice.

I think there are some data, maybe in the health outcomes studies and data from Stanford in arthritic patients, that patients with chronic disease and patients of lower socioeconomic status are particularly at risk with respect to access in managed care and satisfaction with managed care.

I think that those data are not reflected in this. I think Weir's study from health outcomes -- Joe would know more about this than I -- suggested that.

I would look at some chronic disease populations as one of the vulnerable populations. And if you have data on socioeconomic status, you do mention about dual eligibles, et cetera. But if you have data, I think that would be a useful set where you might have an enriched set of findings. That's the first.

The second is I think it would be -- you know, there's an overlap here obviously between access and quality and some of my suggestions may be related more to what some people call quality than access. But I think it would be great to get away from some of these surveys of patients or even doctors with respect to their satisfaction or how they feel about some of this stuff, all of which is really interesting and important. But to add to it some more clinically based, objective information that would suggest problems with access. I'll make one up, it may be wrong, but maybe it will give you the idea.

Let's take breast cancer. I think the standard of care for breast cancer, for someone who has a lumpectomy is to have radiation therapy afterwards. I think the standard of care for breast cancer is to have estrogen receptors measured in the tumor, particularly if you're a Medicare beneficiary.

We should be able to tell whether somebody who had a lumpectomy also had radiation therapy because we would be paying for that. We should be able to tell whether they had estrogen receptors measured or not. I believe there are some early data to suggest that women who are African-American or, and this is not exactly the same but there's an overlap, a lower socioeconomic group are less likely to have radiation therapy after a lumpectomy than other women.

I mean, if there are barriers, for whatever reason of whatever time, to access to certain kinds of care which is the standard of care, then I think that's the kind of thing that we want to know for Medicare beneficiaries. And we would be able, by picking one or two diseases in which

there is an established standard of care that should show up in our files because we paid for it.

I think that would be an interesting supplement to the kinds of surveys of patients and doctors that you might be doing. I don't know if you can do it or maybe it's already begun.

The third question has to do with the last slide Kevin, you talked about hospital financial condition. This goes without saying, but I was assuming that that measure would not purely be the inpatient Medicare PPS margin.

[Laughter.]

DR. ROWE: This is more for Stuart's benefit, who's sitting behind me, but it would be some more global measure of hospital financial condition.

MR. SHEA: I think the discussion we've been having about early indicators or some quicker way of getting information about problems that would come up because of big program changes is a very important dimension and I would concur with many of the comments that were made.

I wanted to add another dimension, though, which is tracking in quick order time the changes or the erosion of access primarily through the increase in financial barriers. I think there may be an important example of this going on, or at least an interesting example of how things change that we know, that seems to be tracking what's happening among active workers. And that is the information, the anecdotes that came up at the end of the year about how many of the Medicare managed care plans substantially changed their financial arrangements vis-a-vis beneficiaries.

I raised this question at one point, I think Jack Hoadley and I may have exchanged e-mails on this. I can't remember what the tracking was or when did we ever get data on this. But from the newspaper reports, some of these changes were really substantial. People had prescription coverage for free and now it's prescription for $400. The kind of thing that among many of the elderly would pose real problems.

So there may be something going on right now that we ought to look at. I wondered if you had any information about that.

But more generally my point is that we know from active workers the situation is there's deteriorating access because of the increasing cost, even in managed care plans. And that we're losing coverage among actively employed people because they can't afford the care that's being offered to them. It's been pretty well documented.

We know from some studies and anecdotal evidence that in the Medicare population the drug costs are at some point prohibitive and so people are choosing between one of a number of drugs that they should be taking or believe they should be taking, or somebody believes they should be taking, and they're not taking them all.

We know that the Balanced Budget Act did a pretty measly job about trying to deal with this outpatient cost problem. So I just wonder if there's anything in the work plan, or could there be in the work plan, something to sort of track these trends, again in short order time and not look at them two years after the fact, and sort of paint a picture more from the beneficiary point of view as opposed to even the clinical point of view?

I just think part of the forest here is if you've got a good picture of what people are

experiencing, it wouldn't tell us whether there were absolute barriers to care, but it would tell us are these problems getting worse? Where are we likely to see these problems come up? What do we need to be, sort of looking at the future?

MS. NEWPORT: A couple of things maybe to look at. At one point, within the last three or four months, at a meeting I was in with HCFA, there was mention of looking at Geo Access mapping for applicants in the Medicare+Choice, and look at up front, which is as close to real time as we might be able to get to, is going in what are not only current contractors what do they have, but what new ones we have. That's a follow up, I guess, to Alice's point. So I think going in that might be a good benchmark to establish, if we can look at that.

Then I would suggest maybe looking at some things that HCFA's Region 9 has done for the last several years, which is publishing on a quarterly basis early disenrollment from plans, longer term disenrollment. Those are crude, but indicators of at least a level of satisfaction or dissatisfaction with plans. So that would flag something, in terms of some things going on.

Another thing on the quality side, which may get to referral issues, has to do with appeals and grievances. And since those are reviewed by an outside entity, what type of overturn rate a plan would have, in terms of they deny something but it's overturned and provided to the beneficiary. Again, relatively crude but you can take a combination of things and combine those to get some indications. So that's a suggestion.

I guess the other part of what I want to say has to do with some -- I haven't looked at this question, but is there any applicability to some of the surveys that are going to be going forward on the Medicare+Choice program? Can you transfer that easily to the fee-for-service side? Is there a way to take some of that HEDIS survey information and do a cohort on fee-for-service that's meaningful? I don't know the answer.

MR. COSGROVE: We actually didn't mention, but there is the Medical Expenditure Panel Survey, the MEPS, which was a follow up to the NEMS of '87. I mean, that's going to come out every year. I've talked to some of the people that are working on that at HCFA and they do have big enough samples to work with of separate Medicare beneficiaries, both in fee-for-service and in managed care, the Medicare+Choice plans. We are planning to take a look at some of those numbers.

MS. NEWPORT: I guess one of the concerns that everyone has and seems to voice, is how is private fee-for-service going to be evaluated? Because this is just a totally new entity in many people's minds, how are we going to look at that and measure that and does that present more particular or less particular challenges?

MS. JACKSON: Some of what I'm going to say has probably been mentioned before, but I just wanted to get my point in.

For the past two or three years, I have alluded to the fact that certain beneficiaries were having difficulty in accessing care, and I almost had to just say that we had it from anecdotal records. But now we have it in the report that there are beneficiaries that are having difficulty in accessing care.

What I would like to know is what are the reasons? At some point we were identifying the fact that managed care and instead of fee-for-service they could go into managed care. If they

are having access problems in managed care, what are some of the reasons why they are having it? And then what can we do about it? And then I have a follow up question.

DR. HAYES: One thing we've done in the past is to use some statistical techniques to try to look at independent relationships between different beneficiary characteristics and their access problems. So we could look and see what role supplemental insurance coverage has on access. Do people with and without supplemental coverage have more access problems than other people?

And that's above and beyond any other unique characteristics that they have. Is there something unique about supplemental coverage that seems to have a relationship with access? Indeed, that is the case.

The other thing that seems to be related to access is just whether or not people have more health problems than others. We look at that self-reported health status. How do you rate your health? Excellent, very good, good, fair, poor. And it seems like those that rate their health as fair or poor seem to have more access problems than other people. And that's above and beyond any other differences that they have with respect to age or what have you. There's an independent relationship between health status and access problems.

And to me those are kind of at the top of the list. Those are the two things that seem to be most important. And so the question then would be if we wanted to go down that road and try and identify solutions for the access problems of vulnerable groups, those are the kinds of things that we would have to zero in on.

Is there something that we could do for those who lack supplemental coverage? Is there some way we could change the benefit package or whatever, to promote access? The same kind of thing, can we target our efforts somehow at those who seem to have more health problems than others? That's another challenge for this group, will be to try and see if there is some special efforts.

As you know, next on the agenda Tim Greene will be talking about vulnerable groups and what might be done for improving access for those groups in managed care. Maybe a question is well, can we pursue a similar effort for those in fee-for-service? That might be one way to think about it.

MS. JACKSON: And since my next question deals with the next topic, I'll hold it until then.

MR. MacBAIN: Just to follow up a bit on what Janet was saying, that is that as we begin to see the growth of Medicare+Choice programs, we're going to see an overall Medicare program that really has a number of options, among which the traditional Medicare plan is only one.

Really, to measure what's happening over time, we ought to be asking the same questions to beneficiaries in all of those plans, rather than what appears to be HCFA's approach of targeting just the Medicare+Choice plans. Otherwise, we lose a benchmark. We really don't know what has changed relative to where things were.

We don't know if access is improved because of Medicare+Choice enrollment, whether that's a good thing or not, unless we're also measuring what happens among the fee-for-service population. We may find in the same region that access has gotten even better for them, or that

it's gone the other way. Without a benchmark, it's going to be hard to make any sense of those.

Similarly, with physician survey, which I think is extremely important as we get into more and more of these options. We want to find out where physicians are participating in each of these various options. If they're not participating in the fee-for-service plan but they're flocking to Medicare+Choice plans and so are their patients, that's more than an interesting observation. It may indicate a real sea change in the way the whole program is moving.

The third thing has to do with trying to get below the observations down to explanations. It's an observation to say that people who report bad health also report difficulty getting care. That's not an explanation. Is it because of mobility problems, because there aren't specialists that can treat the problems that they have? Is it because these folks also tend to be unable to acquire supplemental coverage and can't afford the hospital outpatient copays? Or is it something else?

We really need to be able to cut below just the observation level that we've got right now and try to provide some explanations.

MS. NEWPORT: The other part of this has to do with what is communicated to beneficiaries and how well it's communicated. All of this data that is a requirement that it be given to them, which is great. But we do have at least one gross experience, if you will, with hospital mortality data as a benchmark and too much data that wasn't useful to the end user, if you'll excuse the expression.

I think it's important to have this information. I also think that it's important that we communicate it appropriately and focus groups of people who are the beneficiaries is really critical. Let's find out what they want to know. And then we should tailor things, also, to go after that kind of information.

MR. COSGROVE: HCFA has been for at least a year, two years, has been doing focus groups studies looking at the kinds of information and the format of information that beneficiaries can most easily deal with. They've been doing this in conjunction with a lot of different research institutions and consulting firms.

MS. NEWPORT: Some of the stuff I've seen lately isn't very comforting on that. I'm just speaking at someone who --

MR. COSGROVE: Right. It's a very new science.

DR. HAYES: I think for the next meeting Helaine will be bringing us something on consumer information issues; is that right?

MS. FINGOLD: Consumer protection issues. There's a small problem or a big problem I guess on informational issues. I mean, you're saying what do people want. Sometimes what they want is great, but what they great, they can't always interpret it well. There's a lot of issues about how useful is the data? Are people asking for the right things?

There is a difference of opinion as to what they should get and what they should be concerned with among professional health policy people and what they're really concerned with. So it's very controversial, unfortunately.

MR. COSGROVE: Yes, one survey that I looked at last year surveyed beneficiaries and the overwhelming majority of beneficiaries thought that information on choosing plans is very important. But a small minority only used that information to pick their plan. So there are a lot

of issues there to iron out.

MR. MacBAIN: Just a short follow-up, and that's with consumer information reported in Pennsylvania now for about a decade, risk adjusted morbidity and mortality data, as far as I know there's still no evidence that either employers or beneficiaries have used that information in any systematic way to pick a provider.

Providers, however, have responded in two interesting ways. One is those at the top of the list use it in marketing, which is appropriate. Those at the bottom of the list use it in internal quality improvement efforts, which is also appropriate. So the data does have an effect, although not necessarily the anticipated effect.

DR. LEWERS: On the Andy was just making, patients tell me I don't understand that. So you've got to give them something understandable. Along that line the American Hospital Association and the American Medical Association have proposed to the quality commission a manner in which this can be presented in a very clear manner on what they want. We've worked together on this. We've done focus groups, asking the individuals what do you want to know. We're working in a very simplified manner to present this. We do have prototypes available, if you haven't seen it.

The other question comes down, we've got the issue of how are we going to present this information? How are we going to educate individuals about the access? When it comes down to requiring part of this in physician's offices, you then get into the problem of can a physician basically say well, I participate with this plan or that plan, and is that referring a patient to the plan that the physician is participating in?

Physicians are getting a little uneasy about what they can tell their patients. It goes back to the gag clauses, which thank god have been removed out of the vast majority of the plans, although we know they still exist. So I think you're going to have to look, if you're going to educate individuals, of what can people be told and how can that be presented. Because right now there are a lot of questions regarding that.

DR. ROSS: A number of the comments are addressing the overlap between access issues and quality issues and standards. I just wanted to note that we're going to have two or three papers at the next meeting that are going to deal specifically with Medicare+Choice with quality, consumer protection and also, to get to Gerry's point, there will be some discussion of financial liability.

MR. JOHNSON: Note to Murray, you might to check the coffee in the mornings of these meetings based on the first agenda item yesterday and the first agenda item this morning. There must be something other than caffeine in there.

[Laughter.]

MR. JOHNSON: I just had a very minor comment on hospital financial conditions. I know this has been the subject of some discussion and much denial and --

[Laughter.]

MR. SHEA: We should strive for balance between the two.

MR. JOHNSON: Yes, check the coffee.

[Laughter.]

MR. JOHNSON: But seriously, I know the AHA and others are undertaking some efforts to do a more reasoned research and discussion of this issue and I just might suggest that there may be some opportunity here for some collaborative efforts as they go forward with their study, too. I don't know whether there could be a panel of various type hospitals you report on every year, but it seems to me that there are a lot of people looking at the same thing, and to the extent we might look at some of it together, I mean obviously it's not going to meet all of your needs. We know that.

But at the same time, while similar groups are doing similar things, it would be useful to trade information, even though you might come out in different places.

DR. KEMPER: A couple comments. Since most of our discussion has been on the work plan and the future, just to strongly agree with some comments that Janet and Bill MacBain made that to keep the focus on the program as a whole, at least make sure that that's well covered. Because a number of the proposed data sets, it seemed to me, are going to miss the fee-for-service sector where we have a whole lot of changes going on that could lead to access problems. To me, that ought to be the first priority and over time.

We haven't talked much about this chapter, and what it ought to include. I guess one question I have is what do you see as the take-home messages from the chapter, with respect to access? One question is how is the program doing over time? Another question is how is it doing for vulnerable populations? Now that's in another chapter, but a lot of data, if I understood the facts table, are really in here.

The third question is how does managed care compare with fee-for-service? There's a lot of data here with respect to that last question.

Is that the proper focus and, if it is, I worry a little bit about the fact that people in managed care are different than people in fee-for-service. It may be important, it may not be important to interpreting the results. But just the raw numbers at least raise some questions about healthier people -- since healthier people are in managed care, what does that mean about the responses you get just because they're healthier?

If I understood it right, higher income people are in managed care, which seemed to be at variance about your conclusion about people making trade-offs, financial trade-offs. But all those differences could lead to the comparison between managed care and fee-for-service being somehow invalid. I guess, is that the take-home message? Are we evaluating managed care versus fee-for-service, or is the take-home message more overall Medicare is doing well or poorly? Or is it that these subpopulations, the vulnerable populations, are doing differently?

DR. HAYES: Let me see if I can try and respond to some of that. I guess the take-home message would be -- what we were trying to get at, in terms of a take-home message, would be that this is the Commission's first look at access, it's identification of where it sees the major access issues, and here's a foundation for a work plan that we have at the end of the chapter.

When you speak about vulnerable populations being an important sort of sub-theme in this chapter, I would agree with you. What we can do is draw that idea out more and put something in the work plan, refer first to the work that Tim's doing on vulnerable populations in managed care, and secondly to emphasize more -- if that's the wish of the Commission -- to try to pursue

more some of the access issues for vulnerable populations and fee-for-service.

DR. KEMPER: I guess one question is, do we have prior year's data on these indicators?

DR. HAYES: Sure. The MCBS goes back to 1991.

DR. KEMPER: It may be too late for this report, but are there trends in access that --

DR. HAYES: It's probably too late for this report, but it is possible to look at trends. In general what we've found is that these indicators, at least with respect to fee-for-service, this is the first year that we've been able to look at managed care results. But with respect to fee-for-service, the indicators have not been changing. They've been within a percentage point or two of -- you know, over time.

That was one of the ways that we concluded that access to care was not changing as the fee schedule was implemented.

DR. KEMPER: But we should be taking away some evaluative assessment of managed care versus fee-for-service from this chapter?

DR. HAYES: I don't know whether I'd want to do that or not. I would think about this more as a foundation for where we want to take this work in the future. I think you're right, if we do want to view this more as an evaluative tool, we would want to run some regressions and try and control for the various beneficiary characteristics and see what the independent relationships are among these various factors and the access indicators.

DR. KEMPER: Because when I read the chapter I didn't get the sense that it was focused primarily on that comparison. But when you look at the tables, they really seem oriented specifically toward that question.

DR. NEWHOUSE: Peter, some of that income difference on managed care may reflect the fact that managed care is disproportionately in large urban areas.

DR. KEMPER: I'm sure it does.

DR. NEWHOUSE: I had a number of thoughts on the work plan, mostly for the future, rather than this report.

One of the things Chris Hogan did on PPRC traditionally was Medicare fee levels versus the private market. Those numbers were very widely used. I know our staff resources are constrained, but the question is first whether we have any plans to continue that. And second, whether market now would include presumably what Medicare+Choice plans are paying. The old numbers, as I recall them, were mostly traditional Medicare versus the commercial market, the under-65 market.

I don't know whether it would be possible to continue that or not but I think it would be useful.

DR. HAYES: If that's the sense of the Commission, we will.

DR. NEWHOUSE: We can see how other people feel about that.

DR. LAVE: I think that if we have hypotheses, a basic hypothesis it seemed to me that was being expressed yesterday, was that there were going to be major changes in some of these fees as a result of practice expenses. And that the implication was not that the fees would change, but that the fees would become much more disconnected from what was happening in the private sector.

So I would guess that you would have to do that. And that would lead me to wonder whether or not, in fact, there ought to be some geographic areas that are targeted if we expect that -- I'm trying to follow up on Bill's comment from yesterday which was that there was perceived to be a major difference geographically and that access problems would spring up geographically, and they were going to spring up because of perceived differences between private sector prices and Medicare fee prices.

So it could be that one could do basically sort of a -- I don't know how Chris did it, but a random and then maybe try to think about an area where we think this is a real problem and focus there.

So I think it's a good idea, and I think it's a particularly good idea given the changes in the Medicare fee structure that are about to happen.

DR. KEMPER: Joe, for those of us who haven't been involved in this, could you just explain in a simple way what the data are?

DR. NEWHOUSE: Maybe Kevin or Chris should do that.

DR. HAYES: I can take a stab at it. Chris is here. But essentially what it involved was getting claims data from a variety of private payers. We got claims data from FEHBP, a major insurance company, a large private sector employer, MedStat makes available data on -- and so we put all that stuff together and compared it with Medicare payment rates from Medicare claims data.

The tough thing, in doing that work, and it's become tougher over time, is getting at what's going on with respect to managed care plans. To the extent that they're paying their physicians on a fee-for-service basis, it's hard to get information on what their rates are.

If we were to do that work we would want to probably contract with someone on the outside to go out and conduct some interviews and try and collect as much data as possible, get information on number of enrollees and so on, so that we can try and come up with some weighted averages. I mean, it's doable, it can be done, but that's generally how we've done it in the past and how we would continue to do it in the future.

DR. KEMPER: I do think that would be valuable.

DR. NEWHOUSE: We may want to talk with AHP also about whether data collection might be possible there.

MS. ROSENBLATT: I think there's a vendor that does something just like that, at least for the commercial population. I don't think it's done for the Medicare -- well, it might be.

DR. HAYES: You're thinking of MediRisk?

MS. ROSENBLATT: Yes, exactly.

DR. HAYES: We've had some dealings with MediRisk, and I'll stop there.

[Laughter.]

DR. NEWHOUSE: A second issue I had kind of picked up on one of the comments on private fee-for-service. I think at least we ought to be monitoring, and it would be easy, the extent of enrollment in private fee-for-service and traditional Medicare in the floor counties and seeing if traditional Medicare is going under there, or in some of them.

A third kind of ties to some of the comments about the drug benefit. We know from the

work we've done that the benefit package varies systematically in the coordinated care side by the AAPCC level. The question is whether you can correlate the generosity of the benefit package, in terms of say the value of the supplemental benefits, with the MCBS access questions in any fashion. You might think about that.

And finally, I'm on one side of the debate about geographic access, but I would echo the comments about the geo coding and, in particular what I would hope we would not do would be do something with access by county because county turns out to be a very bad, in my view, approximation to market area. And also, for many of the rural beneficiaries, the closest doctor is actually a metropolitan doctor whereas the usual doctor to population ratio in rural areas assumes that it's not.

Any other comments? We've gone long, but I think we had a useful discussion of where we want to go on access on both the short and the longer run.

I think I'd ask for any public comment at this point, on anything that's been said.

MS. McELRATH: I'm Sharon McElrath with the AMA. I'd just like to supplement what Dr. Lewers said about the SMS survey. We did do some focus groups and we're adding questions into that. It's about to go out and be field tested right now.

The questions are going to look at physician reaction to payment changes going in either direction. I even had asked whether there was any opportunity for the Commission to add in any questions. It's really too late for that, but we can share the questionnaire with you so you can look and see what we did, and see what you might want to add into that.

DR. NEWHOUSE: Thank you, that would be very helpful. Other comments?

[No response.]

DR. NEWHOUSE: Okay, let's move on to Tim.

MR. GREENE: Good morning. This morning I'll be discussion vulnerable populations in Medicare managed care.

Managed care has the potential to offer Medicare beneficiaries several advantages, including greater coordination of care, financial protections, and enhanced benefits in comparison to traditional the Medicare program. These advantages should be of great value to those who are disabled or suffering from chronic illnesses. However, Medicare beneficiaries who are in poorer health or have functional disabilities are less likely to enroll in HMOs than others.

This chapter, which I'll be discussing this morning, surveys the issue of low enrollment of vulnerable populations in managed care. I present an overview of the populations, then I discuss some factors which may be hindering enrollment, dealing separately with beneficiaries and plans. And then finally, I'll be discussing some possible strategies for increasing enrollment, again focusing separately on strategies affecting beneficiaries and those affecting plans.

At the next meeting, I'll present analyses from the Medicare current beneficiary survey on enrollment of vulnerable groups in managed care and of annual Medicare program spending on beneficiaries in each group. The results should be coming out of the computers right now, but they're arriving, I'm afraid, a little bit too late for this meeting.

You may think of the chapter that I'm discussing, that you've seen the text for, as in a sense the words that will be going around the tables in this chapter. I've attached table shells to

the draft document in your mailing material, to give you an idea of the way we'll be presenting the data and some of the data we'll be looking at. I welcome any comments or suggestions on alternative ways of cutting things, subject to the availability of information or not.

Vulnerable populations include segments of the Medicare beneficiary population with attributes that may lead health plans and providers to be reluctant to give them access to appropriate care. Most important are characteristics associated with higher and certain health care costs.

DR. LAVE: Can I ask a question? I don't know whether this is clarifying. I can understand why you would exclude Medicaid because I don't understand the Medigap issue. Because if I'm managed care, it seems to me I don't need a Medigap policy.

MR. GREENE: I'm looking at populations and making comparisons across managed care and non-managed care. For some of this I'm looking at fee-for-service populations.

High cost groups include people with physical, mental and cognitive disabilities. Other groups are those who are very ill, in deteriorating health or chronically ill. The very old are often high users of health care who may find it difficult to identify and obtain appropriate care.

Beneficiaries who have no private or other public insurance to compliment their Medicare benefits may suffer access problems as well. Lack of supplemental coverage combined with lack of economic resources leaves such beneficiaries at risk for financial liabilities due to coinsurance deductibles and costs of uncovered services. In addition, to the extent that they defer services because of out-of-pocket costs, it puts them at health care risk.

Some beneficiaries, the dual eligibles, are covered by both Medicare and Medicaid, but they are often caught in the inconsistencies and conflicts between two programs. We'll be presenting data on them in the final draft and discuss next time and Claire Burnett will be presenting discussion of them in the chapter on dual eligibles at the next meeting.

Socioeconomic factors can interfere with access. Providers may be hesitant to provide care and beneficiaries may have trouble finding it for a population such as those with low education and so on.

I'll be skipping over discussion of previous work by MedPAC, ProPAC, and PPRC. You'll see it in your mailing material.

Coordination of care would appear to hold great promise to overcome many of the problems facing vulnerable populations. Although many times of organizations, including fee-for-service providers, could provide coordinated care, capitated health plans are more experienced in doing so and face fewer barriers from the payment system.

As population based health care organizations are oriented to prevention, capitated health plans are often better able to coordinate care than fee-for-service providers. Payment by capitation may allow plans to allocate resources more flexibly and with appropriate supplemental benefits available, Medicare plans could choose a wide range of providers and even invest in non-medical services.

Coordination of care may be of special value to persons with disabilities and chronic illnesses. Unrelated fee-for-service providers typically have separate data and medical records systems as well as inconsistent practices and often incomplete communication among themselves.

The organization and flexibility encouraged by capitation may be welcome to high users.

Despite these apparent strengths, capitated health plans may be poor sources of care for disabled and chronically ill beneficiaries. Plans are organized to provide care to a largely healthy member. When members are ill, they generally present with a fairly familiar range of acute illnesses, many of which can be treated by the plan's primary care physicians or even nurse practitioners.

However, beneficiaries with disabilities and chronic illnesses make heavy use of specialized services, including but not limited to specialist physicians. Many managed care plans are organized to discourage heavy use of specialized services.

Many beneficiaries are hesitant to join managed care plans and those with disabilities and chronic illnesses are especially hesitant. Beneficiaries have several concerns. First, beneficiaries have historically been hesitant to join managed care organizations that have unknown operating procedures and unknown quality of care. They have been concerned that if they then decide to leave managed care, they will be unable to regain Medigap coverage.

The Balanced Budget Act partially addressed these concerns. The BBA provides the beneficiaries who leave Medigap to join managed care plans and then return within 12 months are guaranteed issuance of a Medigap policy. This reduces the uncertainty facing these beneficiaries.

Most important to Medicare beneficiaries when they consider managed care plans are issues pertaining to choice. It appears that the most important obstacle to acceptance of managed care by the elderly is concern with being able to keep one's physician. People with disabilities and chronic illnesses may be even more concerned about ability to choose their own providers.

Beneficiaries want comparative information on health plans, including information on the choice between Medicare managed care and Medigap. As we were discussing with the last speakers, there's been a great deal of work done on information, making information available to beneficiaries. We know from that, from focus group research and other things, that information must be carefully chosen and presented in a way that's both accessible to and trusted by beneficiaries.

Finally, quality of care and quality of services are major concerns of elderly beneficiaries in assessing managed care. Among Medicare managed care enrollees, those with disabilities or among the oldest old are more likely to report suffering access problems. In part, this may reflect their greater need for services and parallels to some extent the reports of fee-for-service beneficiaries. However, it may also reflect the performance of HMOs in caring for these populations.

Plans and ultimately providers who contract with plans require additional payment to be willing to enroll members with high and variable costs. Such payment requires appropriate adjustment of capitation rates to take account of health risk. If payments do not reflect the estimated costliness, the incentives to select low cost and avoid high cost enrollees are strong.

Payment for those with disabilities require risk adjustment even more than for the general population. Otherwise a plan has an incentive to avoid excelling in care for people with disabilities and chronic illnesses for fear that it might develop a good reputation in caring for them and attract even more such members.

Though substantial advances have been made in recent years, methods of risk adjustment require considerably more development. Most research is concentrated on adjustment techniques calibrated on the general beneficiary population. Such models may or not perform well when applied to subsets such as the disabled and those with chronic illnesses.

Plans can, of course, take various actions to select favorable risks. Although HCFA attempts to monitor and control plan behavior, it can't control all such actions.

Finally, plans may be reluctant to enroll beneficiaries with disabilities and chronic illnesses because of non-cost factors. Such people may present difficulties through treatment for the plans. Plans may be wary of the operational costs in enrolling them and making changes, may be concerned with organizational changes, disruptions and inconveniences involved in adapting to entirely new members.

I'll now turn to some possible ways of dealing with these problems. After that litany of difficulties, it may be puzzling whether we can do anything. You may be wondering what, if anything, we can do. But strategies have been suggested to deal with problems both on the beneficiary and the plan side. I'll be beginning with beneficiaries and then covering some of the same issues that I covered when describing the factors hindering enrollment.

First, much can be done to further reduce the perceived risk in enrolling in managed care. BBA addressed many of these issues, as I indicated, with regard to Medigap. However, beneficiary concern can be further reduced by making managed care and Medigap markets more closely related. For example, both managed care plans and Medigap insurers could be required to coordinate open enrollment seasons annually.

The second area, partial standardization of the HMO supplemental benefit package, say following the example of OBRA '90 when it standardized Medigap plans, would clarify choices and somewhat reduce selection opportunities. If benefits were structured to be comparable to Medigap packages, beneficiaries would be better able to compare Medigap and managed care alternatives. By reducing uncertainty, this would reduce beneficiary risk and possibly ease enrollment in managed care.

Finally, on the same issue of information that we discussed earlier, improvements in information available to beneficiaries would assist vulnerable beneficiaries, as well. Special attention needs to be given, as I indicated, to understand exactly what sort of information is needed by what specific beneficiaries, and to making it available in a way that's intelligible and can be processed by beneficiaries.

Finally, mainstream managed care plans face real difficulties in caring for vulnerable beneficiaries. Policies should encourage plans to adopt innovative approaches to care for these populations. Experts on care for those with disabilities and chronic illnesses have identified a number of innovations that could improve care and facilitate enrollment of these groups.

I've classified them under three broad categories, care management, center of excellence approaches, and specialized organizations. In the first category, I considered case management first. By this strategy, high cost or other targeted cases are identified and their care is managed to prevent deterioration and worsening of condition. Since this can entail bringing in diverse resources, including non-medical ones, to deal with multiple non-acute conditions, it's consistent

with the goals and organizational style of managed care.

The second approach in care management is what's become known as disease management. Here, specific diseases are identified and analyzed and clinical protocols are developed and applied to deal with individuals with these conditions. Some HMOs have developed disease management systems under various names and have applied them widely.

The second general area, centers of excellence, follows the example of work HCFA has done in other areas. HCFA could experiment with bundled facility and physician pricing of services for the chronically ill. In this case, HCFA would pay capitation payments to an organization which would then provide a contract for related medical services, as well as other care, and possibly even for case management.

The third area, specialized organizations, I'm thinking mainly of specialized care organizations. An alternative here, explored by some Medicaid programs, involves enrolling chronically ill individuals largely in plans specialized to meet their needs. This addresses the concern that people have expressed that, in general, managed care organizations are used to dealing with a largely healthy membership and have little expertise in dealing with specific chronic conditions.

However, there is some controversy about the use of specialized organizations because some argue that general managed care organizations can do a better job in dealing with the chronically ill because they're better prepared to deal with and treat the wide range of comorbidities and other conditions that the chronically ill present with and in addition, that specialized organizations might have too narrow a membership and financial base to be supported.

One other alternative, in the same vein, would involve carve-outs of specific functions. Here, a managed care organization can contract with limited service providers that could provide specialized care. These could be capitated or, as in the case of many behavioral health carve-outs in the private sector, could be paid on the basis of a shared risk between purchaser and provider.

Finally, I'm turning to strategies that are, in this case, targeted to plans and concerns that plans would have in enrolling these populations. The most important action that can be taken to encourage plans to enroll vulnerable beneficiaries are steps to discourage risk selection. This can be directly addressed by developing risk adjustment methods applicable to these populations.

Health plan payments are to Medicare+Choice reflect county capitation and demographic risk adjusters. As you know, beginning in the year 2000, BBA requires new risk adjusters reflecting enrollee health status. Several risk adjustment systems are of relevance to care for those with disabilities and chronic illnesses. A disability payment system has been developed using data on Medicaid disabled recipients under 65 years of age and intended for use by that program. However, this system is of limited applicability to Medicare, whose disabled populations differ very significantly from those covered by Medicaid.

An alternative risk adjustment model is the hierarchical coexisting conditions model developed using diagnostic information from Medicare claims forms. We've discussed that before, and Chris has presented a lot of information about application of that to the general Medicare population.

HCCs more accurately forecast costs than other methods using diagnostic information.

We looked at the report by the HCFA contractor on development of HCCs and specifically its performance for those with chronic illnesses. It's encouraging, in as much as the model does appear to forecast costs well for those beneficiaries described as having any chronic illness and for a number of very specific chronic conditions.

So our concern about a model calibrated on the larger population here, we may be in good position in terms of applying it to at least the chronically ill.

We are applying HCC model now to the Medicare current beneficiary survey data. This will allow us to compare annual costs in this for each vulnerable group with costliness after risk adjustment. I'll be presenting the results of that analysis at the next meeting. You can see the sort of comparisons we're intending to do in table six, in the tables attached to your mailing material.

Risk adjustment alone will not be sufficient to ensure adaptation of managed care to the needs and unique issues of vulnerable beneficiaries. Risk sharing such as gradual phase-in of new risk adjustment methods would ease the impact on plans and protect both them and beneficiaries from the incentives to too drastic or too rapid cost reduction.

In addition, with other financial protections for plans such as outlier rules or partial capitation payment systems, plans would be more likely to enroll vulnerable beneficiaries with high variable costs.

Financial risks, as I indicated earlier, are not the only factors discouraging plans from enrolling high utilizer beneficiaries such as the ones we're discussing. Other reasons include resistance to organizational change and unfamiliarity with treating these populations. Policies should seek to counter these non-cost factors and encourage risk selection, and encourage adoption of innovative methods of care, which could increase the familiarity of plans with these disabled and chronically ill populations and better prepare them for caring for them.

In addition to positive inducements, Medicare could set standards for care to those with disabilities and chronic illnesses. Sanctions could be applied to plans if they were not prepared to provide adequate care.

Finally, strengthen the liability rules and stricter legal liability protections would also help prevent plans from stinting on care to high utilizer groups.

In conclusion, vulnerable populations such as beneficiaries with disabilities and chronic conditions have been slow to enroll in managed care. This reflects attitudes and actions on behalf of both beneficiaries and plans. They also reflect inappropriateness of capitated health plans as currently organized to provide the coordinated care from which these groups would benefit. Policies could encourage enrollment and increase the appropriateness of care that they provide to these populations.

DR. NEWHOUSE: Thank you.

DR. KEMPER: A couple comments. One is just with respect to the topic of the chapter, I got a little off track with the term vulnerable populations because I think of that as low income, minorities, as well as people in poor health. You're really focusing on people with chronic conditions and disabilities. It seems to me you ought to just make it clear that you're focusing on that, rather than on the broader set of vulnerable populations.

MR. GREENE: I'm presenting data on the poorer and minorities and so on, as well. I

state in the body of the text that after presenting the introduction, that the focus of the chapter is going to be on these groups. I'm sorry it didn't come through clearly here.

DR. KEMPER: Right, but it also has to do with the other chapter. I think the more substantive comment is it seems to me it's important to be balanced here between managed care and fee-for-service. It's not necessarily the case that people with chronic conditions get great care in the fee-for-service side, as well. I mean, I think it's difficult to manage patients with chronic conditions, no matter what. The lack of coordination there can be a serious problem, as well.

I guess I found at place that just the tone of the chapter was somewhat unbalanced. It seems to me the Commission really ought to be addressing the question of how can the program as a whole be addressing the needs of people with chronic conditions.

I guess my last comment is I am glad that you raised the risk adjustment, because I do think that is an important piece of dealing with the problems, as well as some of the regulatory things.

DR. LAVE: My comments are coming from a different direction. I agree with everything that Peter has said, but actually, we've been doing a study of enrollment in managed care of chronically ill people in the Pittsburgh area. So my reflections are generated by what we found in that study.

They really have to do with the data in the tables, as opposed to the data in the text. The points that I have to make are twofold, and that is I think you want to think a little bit -- when you're trying to make sense about who's joining and who's not joining, and where the decision points are, is it a plan decision, is it an individual decision -- is to recognize that the people who are making these decisions make those decisions under a number of different circumstances. One of which Medicaid is very different from other people. The Medicaid benefit package is as rich as any of the benefit packages that the HMOs have to offer.

So what we have found in Pittsburgh is that very few Medicaid people have enrolled in HMOs. So it seems to me if you're looking at all this stuff, I would use Medicaid and non-Medicaid. I would pull out everybody Medicaid and non-Medicaid. So if I'm looking at poor, I'd pull out poor non-Medicaid and decide who you mean by that.

Because if you think of people joining because of the richness of the package, Medicaid is an extraordinary -- it gives you drugs, it gives you more things actually than the managed care. So if you want to make sense of where the criteria are, I think you ought to pull that out.

The second thing is people have retiree health benefits. Sometimes they don't have any choice. Sometimes they do. Sometimes their plans are not set up or designed for them to have a managed care plan, or sometimes the only way they can get their retiree health benefits is, in fact, to join a managed care plan. So I would also pull out people who have -- you know, I would sort of divide my people into three groups, Medicaid, people with retiree health benefits, and everybody else. Because they are facing very different kinds of decisions.

I think we would get more information from the tables if we looked at what those different groups were doing, because what we found in Pittsburgh is that the people who were joining were the non-Medicaid, non-rich people were the ones who were joining, and the retirees with health benefits whose employers told them this is what you have to do.

It's just another way of looking at the data so we get more information from the tables about where the decision points and nodes are, and can interpret the results a little better.

DR. CURRERI: I thought this was a very thoughtful chapter and I like it a lot. I had one question or one suggestion that I didn't see in the chapter. That is that there is obviously going to be a time factor involved in conversion of the chronically ill, disabled, and particularly the oldest old, as far as their participation in managed care, that I think has nothing to do with what you discussed. That is that, particularly the oldest old, but also those that have been disabled are -- in my own experience, in trying to counsel these people on making these selections -- are very reluctant to make any change.

After all, if you've been in a health system
for 65 years and you're reasonably happy and you're 75 years old or 80 years old, you say BBA has had some provisions that take away some of the uncertainty. Well, they take away the uncertainty of being unable to switch back but they don't take away that uncertainty of I don't want to try something new at 85 years of age.

I think you're going to see with time that change, because you're going to see more and more people in managed care as a result of employment. And those people, as they get into these disabled, chronically ill, and the oldest old, it isn't going to be a change for them. They're going to be more comfortable with it.

I think you have to put something in this chapter that recognizes that there's going to be some decades here before there's going to be wholesale movement, and that even if you did make all these changes with regard to improving managed care in terms of their capabilities of meeting the costs, of coordinating, and so forth, there's still going to be, in my opinion, a fairly large proportion of these patients that just simply aren't going to make a change because of intransigent to change itself.

Somewhere in there we ought to just make a mention in this paper that that's a barrier, and that barrier is not going to go away.

MS. ROSENBLATT: I've got a couple of comments. One is an add-on to what Judy was saying, and I absolutely agree with what she was saying, but I would add one more category, which is those under 65 versus those over 65.

I think one of the important things we need to recognize is that managed care plans in the under-65 market are primarily marketing to employers. This group of disabled would generally not be working. So there's really no marketing, even if they wanted to bring in this disabled, there's no marketing mechanism to get to these people because their over-65 marketing to individuals is really geared to a senior population, I think.

I also agree with the point Bill was making, that I think there is an issue of time, that if one were to look at people who sort of grew up in a managed care environment and how willing they were to take managed care when they turn 65 versus those who didn't grow up in a managed care environment, you'd probably find different things. Maybe that's something we should put on the plate for a future study.

The second thing I want to mention, in terms of the risk adjustment studies that you're doing, there was a study that I participated in with Dan Dunn that Chris has mentioned in his

work that did segregate the groups of claims into sort of high cost claims and non-high cost claims. The finding was that the risk adjustment mechanisms did underpredict high cost utilizers.

I think you're doing a very good study. When we see the results my guess is that you'll have a similar finding, that there's an underprediction among your high cost users.

I did have some concerns about the sanctions that were mentioned on page 10 of the study. One of my concerns is as these sanctions or things like it are imposed on managed care plans, it limits the managed care plans' ability to contract with providers and to channel to a select group of providers that they thing might be able to provide the best care for a group like this. So I just think we need to be careful about how far we go in sort of tying the hands of the managed care plans.

MR. GREENE: On the disabled, I'm using disabled, those with disabilities, broadly. In fact, I expect it to be largely elderly. I wasn't using it to refer to the Medicare categorically disabled. I was talking about the under-65.

MS. ROSENBLATT: So are you saying, are those excluded from the numbers?

MR. GREENE: No, I'm using those with disabilities to include both the categorically disabled under-65, and also those with disabilities whatever age.

MS. ROSENBLATT: That's what I thought. I'm just saying if you were to split it, I think you might possibly find different results.

I also think that one of the things that's going on right now is that current seniors have a choice between HMO, which really limits their provider choice, and fee-for-service, which gives them full provider choice, with a couple of Medicare Select things in there. With Medicare+Choice, it's very possible that that change will create a change to what we're seeing.

If we look at the under-65 population, we're seeing that the point-of-service option is becoming the option of choice because it gives the individual a choice to select a physician out of network and pay more. It could be that that's sort of the missing ingredient in getting more of the seniors to enroll in managed care.

Joe would be very disappointed if I didn't put in my usual about standardization of benefits. I do think that standardization of benefits hinders innovation and that there are some real downsides to standardizing benefits.

DR. ROWE: Tim, I had a couple points. I think this is very well done. Very important, in many ways, I think this is what it's all about. I think what we're here for is to protect the vulnerable beneficiaries, of various stripes and types and in various ways.

One is, I have a sense in reading this and some of the literature, that gee, we need to figure out ways to get more frail or disabled or multiply impaired or chronically ill people into Medicare managed care or into managed care plans because they seem not to want to enroll. And then we give the reasons why it could potentially be better for them.

I think, you know, they're smarter than we think. Maybe it's not so good for them. Just because it's there doesn't mean that we should be pushing them into it. We're very proud of the traditional Medicare program, we've built it up, it's been there a long time, it's served them very well. Maybe they're telling us something.

So I think rather than worry so much about why they're not signing up, we should say

well, you know, there are different products here and that's fine. So it doesn't bother me that they don't sign up, particularly when I look at datas that indicate they may not do so well in it. I mean, it's up to them and I think they should have choice.

Second is, and I wonder whether the PACE program, Sally, in a previous chapter on vulnerable populations talked about that. I don't know if that deserves to be included in here a little bit, because it is a capitated program, or you might mention it or not.

There are those 12, I think now. It started with Onloc and there's about 12 of them around. I think that's relevant to this because it is a managed capitated program that Medicare beneficiaries are in.

Third is I wondered whether there was anything to be learned from the end stage renal disease program, chronically ill disabled people in Medicare for a long time, under a capitated program, whether we learned things about that. In terms of just -- I don't know if there are lessons there. Ted would know more about it than I. I think it's worth thinking about as one of the prior experiences, it's relevant to this population.

Fourth, I think that the issue of comorbidities is obviously very important and you talked about risk adjustment and Chris is here and he's working on that, as well. But I think the big one that is so important that it deserves some special mention if you're writing a chapter about vulnerable populations, is cognitive impairment, dementia, Alzheimer's disease. 10 percent of Medicare beneficiaries have this disorder, a particularly high proportion over age 75. It doesn't show up often as the primary diagnosis.

What you get is a chronic mental impairment and then intermittent acute episodes of pneumonia or falling or confusion or something else. And so they're the ones that get labeled as getting the care. That's a really vulnerable population, I think. I think that mental health in general, but Alzheimer's disease in particular is something that deserves our consideration about whether or not that is something we should approach differently.

Just two more brief points. You mentioned different strategies that different organizations are having about disease management and stuff like that. I think there are some data that have been generated which are very interesting, showing that as opposed to the usual managed care approach of you really have to be effective, assiduous and swift in order to get to the specialist, you know, fight your way through the multiple barriers, thresholds, primary care people, et cetera.

It turns out that specialists in certain areas, such as pulmonary disease or arthritis -- now these are data generated by the specialists who are trying to validate their existence. But it suggests that the care is less expensive and there's much less hospitalization. A good pulmonary doctor on the phone keeps asthmatics out of the hospital, has a sense of who really needs to be hospitalized and who doesn't. A good rheumatologist often, on the phone, can manage patients with arthritis and juggle their medicines and keep them more functional and keep them out of the office or the emergency room, et cetera, with their flares. And it turns out that that's maybe better care and more cost efficient.

That might be worth a mention or a reference. You might talk to the pulmonologists or the arthritis guys. I'm sure there are other examples of cardiologists, et cetera. But I think there

is recognition now that that's cost effective and high quality.

The last point I would make is I think it's worth thinking about disenrollment. We might learn as much about disenrollment as we do about enrollment in managed care plans for patients who are in these vulnerable populations. There are select population that are disenrolling for a reason and we would learn a lot from getting some information about why they disenroll that would supplement the information we have about why they don't enroll. I think that might be helpful.

Thank you.

DR. NEWHOUSE: Bill?

MR. MacBAIN: Just a few comments. One is you mentioned the coordinated annual enrollment period as something that may make it easier to get vulnerable populations in health plans. My suspicion is the opposite is true, that an annual lock-in may serve as an impediment to people who are already hesitant.

Another point is I think you were suggesting at one point that HCFA might establish standards of care for people with chronic illnesses, and I'm pretty uncomfortable with the notion of HCFA beginning to establish standards of medical care. You might want to reword that a little bit.

The third thing is just a follow up on Alice's comments, that for the most part when managed care organizations craft their sales and marketing messages, they're focusing on the bulk of the population. I suspect in a lot of cases they don't even thing about sub-65, younger than 65 Medicare beneficiaries as being out there. Certainly when you look at the advertising messages, there's nothing in there that would make a Medicare disability member think this is for me, too.

It might be interesting to find how many Medicare eligibles were eligible by virtue of a disability in a heavy managed care market, even though this product is for them, as well.

MR. GREENE: We looked at those at ProPAC and we found that enrollment by the Medicare categorically disabled was about half of that for the aged and it varied with markets.

MR. MacBAIN: But how many of those that don't enroll even know or are even aware that it's for them? Because there's nothing in the message to tell you that.

MS. NEWPORT: I associate myself with those remarks, too. The way I've, maybe glibly, parsed this out over the years is for us, in the managed care sector, the under-65 disabled, we weren't being encouraged to market to those, just by the very nature of our approval process for our marketing materials.

I think if you look at something a simple denominator like how many managed care plans out there are called Senior Plus or Senior whatever? The very branding of the products, which has been approved by HCFA --

DR. ROWE: Secure Horizons, for example?

MS. NEWPORT: Secure Horizons is less on point but still, it really does look to that. So thematically there's been, if you will, enablement by HCFA in this.

But having said that, I think that Judy's points on how to segment this population, the under-65 retirees with the employer's benefit packages, et cetera, I think are very important. I think this is very important work and as this segment and these options grow under

Medicare+Choice this is a very important focus we have, but I'd like to see a balanced focus.

One of the things that occurred to me, and I'm not familiar enough with -- I haven't gone through any NCQA reviews personally but operations and medical staff have. Does NCQA take a look at, from a quality standpoint, work that's done by plans in this area in terms of managing chronic care? I think, if not, we should probably encourage that. I think that's an important area to look at.

DR. LAVE: There's something else that came up again as a result of this little project that we've done in Pittsburgh, and that is that it does seem to me that one of the things that we should mention at least a little bit, and I hate to sound like a sociologist, is the importance of families in making these decisions. It really, I think, does make a difference.

I point this out because it turns out that in the Pittsburgh market anyway, other things being equal, people who had families and could talk to their families about what the nature of the choices were were actually much more likely to join up in the managed care world. So some vulnerable people are much more protected than other vulnerable people because they do or do not have families.

My sense again is a lot of anecdotal speeches that parents talk to their kids a lot about what's happening to them in the medical care area and that, for those of you who have old parents, I think you realize that you're spending a lot of time dealing with them in their medical care sector.

So I do think if there's some way of looking at this that it should not be ignored, because it's going to be really a secondary quality control mechanism for older people who have family and children to look after them. I know it sounds sort of wishy-washy, and all that kind of stuff, but my sense is that it's probably more important than we give credit for and I think we ought to mention it.

As I said, in Pittsburgh, it did turn out that people with families talked about these choices with their families and other things equal, it was important in their joining. I'd just mention that.

DR. LEWERS: Thank you. I agree completely with Jack in that I don't think we need to be pushing and pulling this population. I believe that these people can make decisions. I find that they can make decisions.

But I do feel that the point Jack makes about their mental ability, particularly in the older beneficiary. But also, as they begin to age, change is the one thing that's exceedingly difficult. It's difficult for all of us in this room to change and change things that are very dear to us. And health care is very dear to this population. So getting them to change is going to be very difficult.

And what they want is choice. All the studies show that. You've got this in the paper. It's a short paragraph and I would expand that. It's the number one concern of the population over all, but certainly the number one concern of this age group.

If you take a look at the data, and I don't see it here, as I recall '96 data was that 40 percent of the people who went into managed care were able to maintain their physician. That means 60 percent were not. That number is up, but yet I think that 60 percent, to this group in particular, is a very important issue.

Jack mentioned the chronically ill and particularly the diabetic patient. And that's true,

they don't want to change, particularly in the rural area where they do not have the selection that they might have in an urban area, not only to physicians but to facilities.

Jack's right about the specialist being able to provide care at a lower cost, particularly diabetics. We've got to remember, we've got a ton of diabetics in this country and they use a lot of our services and ramifications of the whole program, particularly in dialysis. The vast majority of my patients on dialysis are diabetics and many of them have gotten there because of the care that they did not receive or didn't want to receive, it's a combination thereof.

Along that same line, Peter said that he wasn't sure chronic care was any better in fee-for-service. The last study, which came out a year ago, showed that indeed it is better. That's the one area where quality is better in the fee-for-service program.

The other thing I can't get away without giving my -- I don't think in this group I've given my feelings on Medigap as I had on PPRC, and that is how it increases the cost to the Medicare program and I think that any debate on that fact ought to be included, that it does increase the cost of the Medicare. And those individuals who have it are greater utilizers of the program.

I would ask the question, just because it was brought up, I wasn't going to bring this up, on point-of-service. While that is something that is being more attractive in plans, I think the studies still show that those people who have that option don't use it. It's only, the last study I saw, only 10 percent of the people who have it use it. I think that was the last one.

So I'm not sure what that means --

DR. LAVE: It's an insurance policy.

DR. LEWERS: The point I want to get back to with it is it's another choice issue. They want to know they've got that choice out there. I think that when you're talking about a vulnerable population, choice is critical. So I think that everything you're seeing in this whole process is choice.

I really would like to see a major segment on choice in this chapter.

DR. CURRERI: I think it's choice and no desire to change. I think that as you look at this population, change is just too risky.

DR. LEWERS: It is.

MS. JACKSON: I would first agree with my partner next to me about choice. But one of the things that I wanted to say is that health plans sometimes are reluctant to take individuals who are going to be high cost people. On the other hand, there are people who just don't want to go into a health plan and maybe our report can just indicate that as we publish it.

The real question is how many health plans that reach the individuals who are highly vulnerable are given in grammar other than English? You know, we have a lot of people out there who have English as a second language, and therefore they converse more readily in that. So what do we do about those individuals?

DR. KEMPER: I guess coming back to some of Jack and Ted's comments, and perhaps this is an issue for the longer run, but are there opportunities within the fee-for-service system to increase the potential to manage patients with chronic conditions? I guess we now have a diabetes assessment benefit which may allow physicians to better manage care.

Jack, you talked about the primary care manager being the specialist for certain

conditions. Are there impediments within the fee-for-service payment system which, for particular conditions, might be changed to improve the care?

I guess my earlier point was simply we should look across the whole program with respect to ways to improve benefits. And there may be some innovations, even in the non-elderly in the disease management side which could be transferred to the fee-for-service side of Medicare.

DR. ROWE: The one thing I would add, Peter, just off the top of my head with respect to that is my guess would be that, with respect to certain medications, that some of these people with chronic illnesses, cardiac illnesses in the traditional program had free medications so they wound up saving some. You open up Pandora's box. That would be one change where the physician is out there trying to juggle all these balls in the air and keep all these people out of the hospital and functioning well, and they can't afford to get the medicines that he might want.

They wind up getting admitted into the hospital and they get some of the medicines. That would be one thing, but I don't know the date on that. I'm just basing it on personal experience, managing patients.

DR. NEWHOUSE: Tim, do you want to make any summary comments on this discussion?

MR. GREENE: No. I'm listening to a variety of suggestions.

DR. LEWERS: Could I just ask if I could get one point for clarification, and you don't have to do it now. But on the top of page three, you talk about an expert panel PPRC convened in September of '97. We were in the process of dissolution in '97, and perhaps that's why I don't remember anything about that at all.

But it talks about interest in approach without payment, with payment. I can't recall that. I don't know what that means. I think you might clarify that.

MR. GREENE: Sally Trude presented a summary of that at the November MedPAC meeting. I'm sure it did fall in between --

DR. LEWERS: No disrespect to Sally, who did sneak in the room back there, but I don't have any recollection of that.

DR. NEWHOUSE: Any public comment on this area?

MS. WILBER: My name is Valerie Wilber and I represent the National Chronic Care Consortium which represents health plans across the country. Some of our members include PACE programs and social HMOs, which were mentioned by Dr. Rowe.

I just wanted to make a couple of comments which I think integrate points made across the course of the conversation this morning dealing with chronically ill access and access issues in vulnerable populations.

One of my points has to do with risk adjustments. Dr. Greene mentioned a number of things about risk adjustment relative to the chronically ill. The National Chronic Care Consortium, in conjunction with some partners such as PACE, social HMOs, ever care programs and other organizations that represent managed care organizations, are currently doing a study that we're calling the provider capitation study, to look at this whole issue of how HCFA is recommending risk adjustments under the new Medicare+Choice program.

We're very concerned that the current proposal to use just a diagnostic model which

doesn't take into account functional measures and disability measures for the chronically ill will result in a payment that doesn't really address chronic ill populations mentioned by Dr. Greene who have many functional impairments, and the need for services that traditionally aren't covered by Medicare. So that's one thing that we're trying to look at, is how this new Medicare payment system is going to impact on those vulnerable populations and how a disability adjustment added to the DCG factor would help come up with a payment that's more equitable.

A second point has to do with incentives for provider networks in addition to health plans. One issue mentioned is that capitation under HMOs often leads to greater access to services because providers have more flexibility. But in fact, one of the things that the Chronic Care Consortium believes is that many HMOs have subcontracts with a number of different providers and there's really no coordination across the different providers contracting from the HMO in order to coordinate services and be the most cost effective for the patient served.

We think that PSOs, for example, are a good step in moving forward in ways to bring that incentive down to the provider level. But since PSOs are focused mostly in Medicare and many of the chronically ill are Medicare and Medicaid eligible and PSOs don't take into account the Medicaid benefit, we think that the PSO could go a little bit further and maybe create a PSO for chronically ill and dual eligibles which would include a capitation payment under the Medicaid program, much like the PACE program does.

Another point that I wanted to make about one of Dr. Greene's recommendations about standardization between Medigap programs and supplemental benefits under Medicare HMOs, that would make us a little bit nervous because it's not clear to me that we've had enough opportunity to look at a range of different supplemental benefits that would be useful to the chronically ill population. And to try and standardize that up front, particularly using Medigap as the standard, I think, could result in missing opportunities for providing the kind of services that the chronically ill might need.

Just by way of example, supportive services, whether it's services delivered in an assisted living or otherwise, wouldn't be covered by a Medigap policy. So I think we need more flexibility there.

Then the last point that I'd like to make, and I apologize for taking so much time, but it wasn't mentioned -- at least today, that I heard -- about the need for collecting data on the chronically ill across settings and across programs. That's both cost data and outcome data.

What was mentioned by Dr. Greene is that our system is very focused on an acute care orientation, where we tend to look at what happens on a hospital setting or a nursing home setting or a home health agency setting. We believe that if MedPAC could make some recommendations to Congress about the need to collect cost data across settings and across payment programs like Medicare and Medicaid, that we could get a much better handle on what the true long-term care costs are, what the true long-term costs across programs and services are.

Thank you very much.

DR. NEWHOUSE: Thank you. Other comments?

[No response.]

DR. NEWHOUSE: Why don't we proceed on? Claire, Chris?

MS. BURNETT: Good morning, my name is Claire Burnett, and this is Chris Hogan. We're here to talk to you this morning about a new topic to the Commission, and that is care for people at the end of life.

First, I'll give an overview of Medicare spending. Second, I'll discuss potential for cost savings. Third, I'll explain some financing issues for palliative care. Fourth, I'll highlight a few quality of care initiatives. And we'll conclude with a sketchy plan for future staff work if you're interested in this topic.

While there are a host of psychosocial, ethical and spiritual issues associated with this topic, this talk will focus only on related financing issues.

The Medicare program has a profound impact on care for people at the end of life. It insures over 70 percent of the people who die each year and funds over 80 percent of all hospice care. People who die have a significant effect on the Medicare program, as well. Over one-quarter of Medicare costs are for people in their last year of life.

Medicare pays for a substantial but highly variable portion of the care delivered to people in their last year of life. In 1987, Medicare paid for a large amount of acute care for decedents but covered only a small amount for nursing home and other supportive services. Keep in mind that services like nursing home care, for instance, mainly are covered by Medicaid and private sources of insurance. So Medicare expenditures do not necessarily reflect total medical spending.

Let me give you an example. Medicare spending in the last year of life is lowest for the oldest old. Since in general persons 80 and over receive relatively less intensive services but obtain instead supportive care from nursing homes and home health services that would not be covered by Medicare.

Medicare spending is disproportionately concentrated on the last year of life. Lubitz found that around 28 percent of annual Medicare expenditures were accounted for by the 6 percent of beneficiaries who died each year.

Medicare expenditures are further concentrated in the last months of life. Lubitz also found that almost one-half of costs in the last year of life were spent in the final two months.

It's been well established that most people die in a hospital. In 1992, for example, almost 60 percent of all Americans did die in a hospital. A recent study by Wennberg, however, demonstrated huge regional variation in the site of death when he found a more than twofold variation across small areas.

Service mix for Medicare beneficiaries is similar for survivors and decedents, save for an apparent tradeoff between physician and hospital services. Most notable here is that spending for hospice care was very small, even for decedents, in 1995. The reasons for this will be explained in more detail later on in this presentation.

The high proportion of Medicare spending in the last year of life has led many to look for cost saving measures only to be disappointed. Advance directives, those statements about how people want to be treated if they become critically ill, have not been found to lower costs. This may be related to timing, as the typical advance directives are issued less than two days before death.

Similarly, of the two studies about managed care and end-of-life costs I was able to locate,

one suggested that there was less potential ineffective care while the other found no significant differences between managed care and fee-for-service costs.

By contract, the earliest and perhaps best study of hospice care by David Kidder found that Medicare avoided $1.26 in fee-for-service costs for every dollar spent on hospice. These savings diminish as the length of stay increases, as most savings are generated from less hospital use in the last month or two of life.

While hospice may lower costs, it's hardly a panacea. Hospice is a benefit offered under Medicare for patients who are terminally ill. That is, expected to live six months or less. It provides palliative care, which focuses on the relief of pain and other symptoms, as well as providing psychosocial and other supportive services to patients and their families.

Almost 80 percent of all hospice care is funded by the Medicare program, which spent about $2 billion in 1997. Presently, only about 15 percent of decedents receive any hospice services. There may be two reasons for this. The first is that some beneficiaries are not interested in hospice style services. The second is that hospice may not be appropriate for many beneficiaries. Lyndon Wilkinson's Illness Impact Trajectory illustrates this point.

In order to refer patients to hospice, providers must be able to predict when a patient will die. Cancer patients, for example, typically have a period of functional stability and then a relatively predictable and brief final phase of decline. This does allow for hospice referral.

The great majority of Medicare beneficiaries, however, die from other causes of death and fit the line labeled there as congestive heart failure. These beneficiaries experience a slow decline from chronic illness that's generally ended by an arrhythmia or infection which is an unpredictable event and does not allow for a hospice referral.

So while a hospice may provide quality palliative care and cost savings, its use is limited by the unpredictability of death.

Hospices are not the only means by which beneficiaries get palliative care. Current financing systems, however, may impede beneficiaries from receiving this care. A recent Institute of Medicine report argues that hospital payment policies may discourage physicians from providing palliative care since until recently there wasn't a palliative care DRG code.

This can be a problem for some beneficiaries, as some palliative and pain treatments like radiation may only be administered in a hospital. HCFA is now testing a new DRG code which was designed for Medicare beneficiaries who need palliative care related to their primary diagnosis. The results of their study are due out at the end of this month in the Federal Register.

Physician payment policies may also lack a mechanism to reimburse physicians for palliative care. Evaluation and management codes, those which physicians are most likely to use for supportive care, do not distinguish between some important characteristics of patients. These include physical and cognitive impairments or special education and counseling service needs, which may be especially relevant for people at the end of life.

When people do receive palliative care, there is substantial reason to doubt the quality of this care. The SUPPORT study aptly illustrates this. This was a two-part study that first observed the process of care for dying patients. Phase one found that communication between patients and providers was greatly lacking, undesired aggressive treatment was frequently

delivered, patients experienced high levels of pain, and DNR orders were filled out just barely before people died.

Part two consisted of a very intensive intervention to address these problems and was pretty much a complete failure. Quality of care was not improved on any of these measures.

These findings has stimulated interest by many organizations. United Hospital Fund of New York and the Robert Wood Johnson Foundation, for example, are both currently funding multiple projects to improve care for the dying. George Washington University has authored a proposal for a capitated program that would expand hospice services to more people. There are many others as well.

Before I talk about the work plan, let me recap. The Medicare program dominates this area of the health care system. The quality of care that's delivered to people at the end of life, however, is greatly lacking and a hospice, which may be able to address some of these problems, is limited by the unpredictability of death.

Currently, there are many research and delivery initiatives that are underway.

If you, the Commissioners, are interested in this topic, staff need direction for the June report and have sketched three areas for further analysis.

Thank you.

DR. NEWHOUSE: Comments on this area?

DR. ROWE: I have several comments I'd like to make, Claire. I think this is very, very important. This is a national embarrassment. This is the worst of what we offer our Medicare beneficiaries. American health care is focused on cure and we have failed to adequately educate our physicians and other providers with respect to very substantial known information about how to take care of patients.

I'm attending this month in medicine. I go on rounds every morning with the house staff when I'm not here at MedPAC. I think I work at a good hospital. You see it every morning. You just don't know how to do this. There are people in our building who know how to do this, but the students and most of the doctors don't know how to do this.

This is not a cost issue. I don't think that this is how can we spend less money on people who are dying? It's how can we provide better care? I'm not looking to spend more money, I'm just trying to do a better job.

And I don't think the SUPPORT study failed. I think that this SUPPORT study was a great success and it showed that the intervention was not effective. But I think the SUPPORT study was a very important, courageous and significant investment on the part of the Robert Wood Johnson Foundation that really brought this issue to some national attention.

Let me make a couple of comments. Rose, Sitofsky and others have published data which people find irresistible. We've got a couple of tables here, even Chris and Claire fall into the trap, the proportion of money spent in the last year of life. Which year of life would you expect it to be spent in? The middle year of life? I mean, of course.

This is like the old joke about somebody studying train wrecks and finding that most of the fatalities are in the last car, so the answer is eliminate the last care of the train.

[Laugher.]

DR. ROWE: Of course, the expenses are in the last year of life and we shouldn't try to figure out how to avoid the expenses in the last year of life. We should accept that that's the way it is, and we should better spend the money in the last year of life.

On the third page of your chapter, which is very good, you noted the interesting study from Canada by Ruse that showed actually the older you are the more expensive it is, the longer it takes. I'd refer you to Seminal Observation of Geriatric Medicine by Sir Bernard Isaacs back in the 1950s. He labeled this phenomenon pre-death. The older you are the longer it takes to die. 45-year-olds who die, die very quickly. It's in the textbooks in geriatrics and it's an interesting historical thing that we've come back around to it.

Hospice advance directives, hospice is great if you're wealthy and white. Apparently nobody else uses it. Minorities appear not to have access to hospice. I think less than 1 percent of the users of hospice are minorities. Advanced directives, getting them written is great except they usually stay in the nursing home and they don't get transferred to the hospital. And if they do get transferred to the hospital the doctor ignores them. So these are strategies that were worth a try.

DNR, I think, also you mentioned appropriately, it's written hours before the death of the patient. It's the last rites. That's what it is. It's a medical form of last rites. It does not reflect coordinated discussion and planning.

So what we've done is we've tried a bunch of things and they don't seem to work. I think the major, if I had a nickel to spend on this, then I'll shut up, I would try to use the Medicare program to educate physicians in training, whether they're medical students or residents or fellows or practitioners, in the content areas of palliative care. And I think it would wind up improving the care of elderly beneficiaries of Medicare and it would probably reduce costs because there are a lot of things that are done to people that are dying that shouldn't be done and are very expensive.

If we could find a mechanism to facilitate or incent physicians education of physicians in palliative care, I think that that would have a beneficial effect upon the Medicare beneficiary. Thanks very much.

DR. MYERS: I don't disagree with Dr. Rowe and especially with his expertise in this arena, but I wanted to enlarge and enrich upon perhaps his explanation with a couple of caveats regarding his process. Most of my clinical time has been spent in the intensive care unit where most of the patients are clearly in a high risk state and where a significant portion end up dying.

I therefore would caution you, with respect to your interpretation that you offered in, I forget which of the studies, and what family desires are. Family desires change over time. Family desires on the day that you enter the ICU are different than family desires on the day before and the day during death. Depending on when you ask the question you'll get a different answer.

It takes families and relatives a while to adjust to the dying process. I would suggest to you that we have a phenomenon in the United States that I like to designate the mandatory miracle. You've seen it on television. Somebody was supposed to die, goes in, and miracles happen and they don't and they're on the news that night.

Every American seems today to want his or her mandatory miracle at the point in time

where a loved one is dying. And they think that if they push hard enough and ask hard enough and do all the right things, then somehow they can extract that miracle from the physicians in the hospital and the providers at that point in time. So just be cautious in what you see there.

The other issue that Jack raised is a very important issue, and those are the cultural differences in how we die. The facts are that many African-American patients, I think, are rather distrustful of the system when a relative comes into the hospital and early in that admission someone is discussing with them stopping care when, in fact, they've experienced a lifetime of denials and access problems to care.

I think that where one has been and one's history influences directly one's attitude towards advanced directives, towards DNR orders, towards hospice, and towards all of those things that other populations I think accept more readily and understand and feel more positively about. So be also careful in how you interpret and in your understanding of that issue as well.

There are a couple of groups that are actually studying now the issues related to cultural differences and how we die in America today. I don't know what the status of that research is but that might be something that would be informative to you as you pursue your research, as well.

DR. LEWERS: Jack and I aren't coordinating our comments, but I agree completely with him. We have studied in American medicine prenatal care, well-baby care, we've done everything at the beginning of life. We've done nothing at the end of life. This is an embarrassment.

But the American Medical Association has undertaken this because of our end-of-life studies that we've been doing in the physician-assisted suicide area because part of the problem with physician-assisted suicide is our lack of care at the end of life.

So we have a major undertaking to study this area, where the needs are, how best to educate physicians, how best to basically educate the public on matters of this area. I know we'd be very happy to participate with you and give you some of that information. Linda Emanuel at our ethics institute is the one who is shepherding that.

But I think there's another area that I call the Marcus Welby syndrome. For most of the people out here, they don't even remember who Marcus Welby is. It was a TV show where everybody lived, nobody died. You've got to remember, you've got a population dying now that grew up with Marcus Welby. They see, as Woody has said, when you go in the hospital you walk out.

Before that time, the population thought a hospital was a place to go to die. Some of the information you have here, the low rate of death in nursing home, is because they're all shipped out to the hospital to die.

I think you've got to look, as you begin to study this process, of how we were trained and the thought process of the people now that we're dealing with. I commend you. I think that this is an area we need to spend a lot of time on and should have done a long time ago.

MS. ROSENBLATT: I just want to add to the comments already made and say that I'm thrilled to see this on our list of agenda topics. I think it's desperately needed.

I'd like to take a minute to relate a personal experience that recently occurred. I recently had an 88-year-old aunt pass away who was living with my 84-year-old mother. Talk about an embarrassment, my own experience as a family member, dealing with the health care system, now

the family totally recognized this was a situation where there was no miracle possible. Based on the chart that was up there, it was a cancer situation, so it was a situation where the deterioration was known.

But what was totally lacking in my experience, and I asked Jack for some help because luckily I personally have enough contacts and Jack was able to provide some assistance, was sort of a plan. I mean, what would have been very nice for my mother and the rest of the family was somebody that they could sit down with who would say this is the deterioration that's going to occur. When these activities of daily living can no longer be done, that would be a good point to consider hospice.

I think the hardest point for us to decide was when home health care was no longer the right thing to do, and you've got to visualize these two elderly women living in a one-bedroom apartment with beds two feet apart. And just certain activities of daily living that can no longer occur at home make movement to a hospice, I think, the desired course of action. Others may select other options. But just somebody sitting down and going through all that.

If there's any way, I think one of the things that was missing from the chapter -- and I thought it was a very well done chapter -- might be dealing with the impact on the family members, as well.

MR. MacBAIN: You asked whether the Commission was interested in pursuing this. I think we are. I think this is an excellent first start. It really gets the issues on the table.

In terms of the June report, I would like to see something that has less financial and more qualitative information in it. I think Jack is absolutely right when he says that the observation that 25 percent of Medicare expenditures are in the last year of life doesn't mean that we've discovered the source of cost. We've simply discovered that Medicare uses the last year of life to provide 25 percent of the financing for the health care system.

It's not a useful observation for managing costs. But I think that a lot of the things that you touch on in here are very important just for the way the care is provided.

Ted mentioned the Marcus Welby generation, the baby boomers, and most of us haven't really admitted to turning 30 yet. We're going to be much, much worse when we enter our 70s and 80s. If the system that we're relying on to care for us as we age is going to be able to deal with that, things are simply going to have to change. We're not going to be able to use the existing approaches.

DR. ROWE: In that regard, just very briefly, with all due respect, an excellent job you've started to do on this. If you look at your recommendations at the end of the chapter, in terms of the work plan, they're almost all financial. This has got nothing to do with finance.

Those are unfortunately the data you have and this is the Medicare Payment Advisory Committee, and I recognize all that, and we each -- everybody comes here, I guess, assuming that we're still trying to wring some more costs out of this every day. But that's not why I'm here. I think this is an area in which we could really think about some of the quality issues.

DR. NEWHOUSE: I agree with that, that in fairness to Claire and Chris, they do cite Emanuel and Emanuel that there really isn't much there.

DR. ROWE: They certainly do. But then all the work plan projects are on finance.

DR. LAVE: I guess I want to come back to the point where Jack started and that is sort of what we make of the cost numbers. I think that what we should make of the cost numbers is you spend money on people who are sick and people who are dying are sick. I mean, it's the same thing that everybody is absolutely horrified about the fact that 5 percent of the people make up 25 percent of expenditures.

Basically, if you sort of look at the national population, only about 5 percent of the people get 100 percent of the payments of people who die. So I do think that that's really what it's saying.

That was the point that I thought Ann Sitofsky was making, which you really didn't pick up. I think it's an important part because I think there is an inherent belief that, in fact, that if the care were more humane and more sensitive, that in fact it would probably cost a lot less. I think that there really is an implicit belief that a lot of the stuff that we do is very expensive and useless.

But that, I think, is the big point, that people who die are people who are sick. And therefore, that's one of the reasons that they use a lot of medical care expenditures. That really doesn't kind of come -- it is just so obvious.

The other thing that we've been looking at that I think is of some relevance, and that is if you look at the costs of taking care, and this is again pneumonia, of people who die, is that we really spend for pneumonia cases -- actually, there's much less money spent on old folks who die than young folks who die. So that you know, you sometimes do treat people intensively, so you have to be very careful.

I think it's just a matter of if you're dying you're sick and if you're sick you use resources.

DR. KEMPER: I guess this is a very moving discussion and a very well done chapter. I guess I, at the end of the chapter, in terms of work plan and thinking of the discussion, the question is what should we be doing about it? It seems to me that there are two thrusts of things that could be done.

One has to do with what I think is a decades long education effort of physicians and beneficiaries in this area and a change in attitudes towards intensive interventions. I'm not sure what can be done on those fronts, but it seems to me it's something worth thinking about.

The other is more short run, and that is in the palliative care side, to make sure that barriers to that are eliminated or at least considered as part of it. Maybe some thought could be given to that.

I guess as I look at the work plan suggestions, I'm a little less comfortable with those in the sense that let's say that you did an analysis of trying to predict who would die and you could actually do that well. I suspect it would be pretty hard to do, but not being a clinician I'm not sure.

But let's say you could do it well, what would you do with the results of that study? That seems to me something that's much more clinical and more, in Alice's case, the oncologists would know the trajectory of care for cancer and maybe the other specialists for other kinds of conditions.

That's where I was a little troubled, is where to do next on the work plan and maybe that isn't so critical to have in this report, but certainly something that's important to give thought to.

MR. SHEA: For the June report would it be possible to do a little write up of what HCFA is currently doing? I know you mention through the chapter here, HCFA this and HCFA that, but given the discussion or the gist of this discussion that maybe we should be -- I sense we might be moving towards a recommendation on something other than sort of just the financing.

It would be helpful to know what HCFA's -- the range of things that they're doing. Because maybe we'd wind up recommending stuff that's already in the works, in which case we could save ourselves the trouble.

But maybe we'd find ourselves in the situation where, judged against some of the standards which we're putting on the table here -- at least in this brief discussion this morning -- HCFA is not paying attention to real issues. And if so, we might want to say something like that.

MS. ROSENBLATT: I just wanted to make one other suggestion based on my experience with the system recently. There is some barriers to care that are real basic, like the home health care provided to my aunt did not include weekend care which, you know, just doesn't make any sense at all. I don't know if that's because we weren't aggressive enough with the system, because I saw your look of surprise, Chris, but if there are some issues like that that we could bring to the attention of the professional bodies, that might be a helpful input.

MR. SHEA: I assume there's nothing on this in the BBA.

DR. NEWHOUSE: Not that I recall directly.

DR. HOGAN: There's a general direction to HCFA to look at issues of better coordination of care in the fee-for-service, and that's it.

DR. NEWHOUSE: And I think it's fair to say that the motive, the political steam behind private fee-for-service, in fact, was care at the end of life.

MS. BURNETT: I have spoken with some people at HCFA and they're very interested in this topic and they are constrained in what kind of work they can do, so they would love to do more demonstrations but they're not able to. So they were very interested in working with us.

DR. NEWHOUSE: My take on this is considerable interest in the Commission and probably we should make this a retreat issue for where we go with it.

I had a couple cites for you to kind of flesh out the discussion. One actually goes to potential work plan issue, although it is on the financial side. And I do agree with the thrust of the discussion that we had.

There's one of Jim Lubitz' studies, I don't know if it's one of the ones you're citing or not. The data that I recall are '78, and I don't think he ever did this. But what he did with the '78 data was show the distribution of spending for people who died.

What was striking to me was that he gave a number, which I don't recall but it was a large percentage of the total dollars on people who died were under $15,000 in that year, which seemed to me to be actually quite low. And it fits the general gist of kind of Emanuel and Emanuel, that there's not a lot to be saved, and it also kind of fits the notion that we're obviously going to spend money on people who are sick who are going to die. And $15,000 in 1978 was obviously a lot more than it is now, but still if you think about one hospital admission could easily amount to that.

So we might want to update that kind of figure, the distribution of spending. I think we could do that.

The second is kind of elaborating on a point that Judy made, and it's kind of an old Ann Sitofsky point which is you can't forecast in advance the year of death. The study that is very nice on this point is a study that Alan Defsky is the first author and George Thibault is the senior author in the New England Journal in about 1981. The did a study of a sample of patients entering the Mass General ICU, all ages. And they asked for the probability that the patient would likely survive the hospital stay.

The idea of the study was to see if a lot of money was being spent on people with very low prior probability of survival. What the finding was was, in retrospect not so surprising, but was that disproportionately the big spenders were the surprises in both directions. That people who were expected to live who died, and people who were expected to die who lived. And if you think about it, this is kind of sequential decision-making.

Under uncertainty it's natural that you will, if you expect somebody to live and they go south, that you're going to probably do more than if you expect somebody to die. And those people are part of the deaths, of course, that we're spending money on. Conversely, the person who you expect is not going to survive but somehow keeps hanging on, you're going to start to ramp up your efforts probably.

So you might want to flesh out the discussion on that.

Any final comments before we adjourn?

MS. JENSON: There was a question, I guess, about whether there were any changes under BBA regarding the hospice benefit. There were a variety of minor changes, but one that might be related to this discussion is that they've changed the definition of the benefit period. Now beneficiaries will have more opportunities to elect the hospice benefit and to move back and forth between the traditional Medicare program and the hospice benefit. That may change.

DR. NEWHOUSE: Isn't there something about a rolling three month period as you go on?

MS. JENSON: Right, before you had two three month benefit period and then an indefinite benefit period. And now you can have pretty much as many two month benefit periods as you would like.

DR. NEWHOUSE: I'd like to ask for public comment.

MS. HAKIM: I'm from HCFA, Rosemary Hakim, but I also was one of the SUPPORT investigators. I just wanted to give you a few little facts or things we found in HCFA.

With all due respect to Dr. Myers, who's left, but the ICU doctors were the worst at respect patient rights. One thing that happened in the study is we enrolled patients who we predicted had a 50 percent chance of dying in the first year after enrollment in the study. We found basically that cancer doctors were the best at respecting patients wishes and avoiding high cost care when it wouldn't help, and cardiologists and ICU doctors were the worst, regardless of their predicted chance of survival.

Another thing I wanted to say is we've written a couple of papers on cost. Joan Tino wrote the paper on advanced directives and how they don't affect the cost of dying. However, we also wrote an earlier paper where we found that people with DNR orders are cheaper than people with no DNR order.

But to complicate the fact, if the doctor and the patient agree to have a DNR order, and it's not just a one-way street that the patient wants it and the doctor doesn't, or the doctor wants it and the patient doesn't, when the patient and the doctor agree that they want a DNR order, they have the lowest cost of dying.

Another thing I wanted to say is, in answer to your question, it's very possible to predict death in groups. For example, we enroll people with a 50 percent chance of dying and 50 percent of them did. But it's impossible to predict in an individual case. That's one of the problems with all these medical predictive systems.

DR. KEMPER: But those were based on clinical data by clinicians, not with claims data.

MS. HAKIM: Right, it's all based on physiology. It's all based on patient's acute status when the enter the hospital, their temperature, their white blood count, all that. So you're right.

But even with that kind of precise prediction, you can't predict individual death very well because it just doesn't work. With the very, very ill, it doesn't work very well.

The last thing I wanted to say was we did find a huge cost saver result. We found that Swan-Ganz catheters for ICU patients don't do any good.

DR. NEWHOUSE: Thank you very much.

MR. GILEO: I'm John Gileo, the Director of Public Policy and General Counsel for the National Hospice Organization. I'm not sure if you all know who we are, but we represent the overwhelming majority of hospices in the United States, as well as 5,000 hospice professionals. We have a professional staff of 26 right across the river, and for the last 12 months have been convening a panel of physicians, academics, other professionals to look at the barriers to access for hospice care of Medicare eligible patients.

I want to invite Ms. Burnett, Mr. Hogan and the rest of your staff to meet with our staff, to take advantage of the research capabilities and the databases and all the members that we have to work with you. We are absolutely delighted that the Commission is addressing this issue. I'm accompanied by Ms. Chris Cody, who is our Director of Professional Regulatory Affairs.

DR. NEWHOUSE: Thank you. I think you can expect a phone call.

MS. WILLIAMS: Deborah Williams, American Hospital Association. I noticed that you mentioned the Wennberg study. I just want to make sure that you all have a copy of -- if you don't, we'll make sure you get one immediately -- of the Dartmouth Atlas with the chapter Death and Dying in America. Good.

Our future activities, we're kind of revving up our plans in this area. We do these serious of focus groups, the first of which settled on how patients feel about hospitals. We're going to do one on focus groups with patients in this area about how they feel about their care at the end of life. Our code word for it in the organization is we call it reality check.

Also, we've worked a lot with the Picker Institute on patient perception. Just to let you know, they have recently received a grant and they're going to do some measures about patient perception at the end of life, also. We could come over and talk with you about it. We'll arrange for that. Thanks.

DR. NEWHOUSE: Thank you. Other comments?

DR. LEWERS: I have one. I just want the record to show that our end of the table

survived the Commission.

[Laughter.]

DR. NEWHOUSE: We'll meet again in two weeks. Hope to see you all then.

[Whereupon, at 11:58 a.m., the public meeting was adjourned.]